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ABSTRACT

A study examined the changing nursing competencies considered essential to meet the patient/client needs in hospitals and community settings in the United Kingdom. First, literature on the following topics was reviewed: required competence at the point of nursing registration; changing nurse roles and competencies; adult nursing in community settings; contemporary mental health nursing; multidisciplinary and interagency working; and shared learning proposals and practices. Next, 630 nurses practicing in community health settings (285 mental health and 345 adult nurses) were surveyed. Most of the 419 (66.5%) of nurses who completed questionnaires gave education high priority; however, they also called for creation/maximization of opportunities for shared learning within an explicitly practice-led, research-based, and employment-focused framework. There was considerable debate around the development of a flexible, collaborative framework at the interface between health and social care. Nurse managers and educators expressed concerns about skills development in both the adult and mental health branches, and managers complained that Project 2000 graduates lacked basic managerial skills. (Eleven tables and 293 references are provided. Included in the 14 appendixes constituting approximately 30% of this report are the following: list of interviewees by job title; interview and focus group questions; questionnaires; competency lists; and information about the study samples.) (MN)

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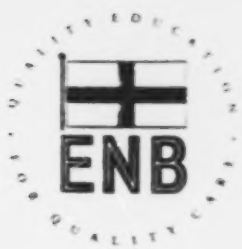

MAPPING THE NURSING COMPETENCIES REQUIRED IN INSTITUTIONAL AND COMMUNITY SETTINGS IN THE CONTEXT OF MULTIDISCIPLINARY HEALTH CARE PROVISION

(AN EXPLORATORY STUDY)

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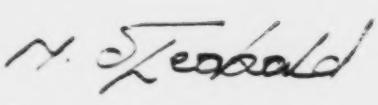
MAPPING THE NURSING COMPETENCIES REQUIRED IN INSTITUTIONAL AND COMMUNITY SETTINGS AND IN THE CONTEXT OF MULTI-DISCIPLINARY HEALTH CARE PROVISION (AN EXPLORATORY STUDY)

PREFACE

The Board is pleased to publish the report examining the range of nursing competencies within the changing context of the national health service. Nursing competencies are mapped for patient and client care in both community settings and in hospital/residential settings. The projected changes for nursing are analysed and those competencies common in either setting are discussed. The primary care led, multi professional and multi-agency health care context, provides the forum for survey opinion informing the study.

Through a variety of means the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence provides a further important dimension for the development of policy. The findings from all the research commissioned by the Board will be considered with a view to confirming or developing the Boards educational policies.



Maureen Theobald
Chairman of the Board

Professor Jeff Thompson
Chairman of the Research and Development Group

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Participating Organisations

Staff of the following institutions were all involved in all three phases of the project:

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Coventry and Warwick College of Nursing and Midwifery
Coventry Healthcare Trust
Durham and Teesside College of Health
North Yorkshire College of Health
South Cleveland Community and Mental Health Trust
Walsgrave Hospitals NHS Trust
York Health Services NHS Trust

In addition to those listed above we visited several other organisations during the course of the study.

We cannot sufficiently express our thanks to all in these organisations who not only gave of their time in responding to the demands of the data collection techniques, but also donated space and administrative time to ensuring that our visits were used to maximum effect and our creature comforts met.

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About the Report

Set after a short description of the background to the Project, **Chapter 1** describes the methodological approach adopted by the research team. **Chapter 2** contains a review of the literature related to mental health and adult nursing, multidisciplinary working and shared learning. The following five sections present the findings of the qualitative study which was designed to identify the changing competencies and interprofessional relationships required of contemporary nurses. **Chapter 3** describes the contextual issues related to the organisation of care delivery, and sets out some of the political imperatives and market tensions described by trust managers and practitioners. **Chapter 4** describes the changing care provision for those with mental health needs, and the impact of these developments on the nurses who work within this service. **Chapter 5** reflects similarly on adult nursing services. Whilst references are made throughout the report to nursing in the community and multidisciplinary care provision, **Chapters 6 and 7** focus specifically on the primary care and the multidisciplinary team respectively. The educational implications of service delivery changes as envisaged by service managers, educationalists and practitioners are explored in **Chapter 8.** **Chapter 9** presents the findings of a survey designed to locate or 'map' the practice areas in which developing competencies are being addressed, and in which students can best achieve the required skills. Finally, **Chapter 10** summarises the main findings and discusses their developmental implications.

In April 1994, the North Yorkshire College of Health Studies and the University of York were jointly commissioned by the English National Board for Nursing Midwifery and Health Visiting to conduct an exploratory study designed to identify the changing nursing competencies essential to meet the needs of patients and clients in both hospital and community settings. It was a prerequisite of the study that the report should offer advice to the Board regarding the most appropriate practice placements for the achievement of the competencies required for parts 12 and 13 of the Register The study was undertaken between May 1994 and October 1995.

At the time of its call for proposals the Board cited within its rationale commissioning the fundamental changes which have taken place in the management of the National Health Service. These include the application of market principles to health care delivery; multi-professional and multi-agency collaboration; technological advances; consumerism and the emergence of a primary care led national health service. Consequently in the context of current organisational and environmental change, the project aims include the following:

- mapping the range of nursing competencies currently required to care for patients and clients in hospital/residential settings and identifying the probable projected changes;
- mapping the range of nursing competencies currently required to deliver health care to patients and clients in community settings and identifying the probable projected changes;
- analysing existing and projected commonalties and differences between the nursing competencies in the two care environments.

The project concludes by indicating the optimum locations for practice placements for students undertaking programmes leading to entry to parts 12 and 13 of the Register.

The research team were required to carry out a study which would inform the future development of a functional map of competencies. Given the extensive area to be described (adult and mental health nursing in hospital and community settings) and the period for which the study was commissioned (eighteen months) the research team assumed the role of explorers rather than cartographers. The report presents a description of the overall terrain with particular reference to the changing competencies required currently and in the medium term. Within the document it is recognised that health authorities and NHS trusts are subject to less and less central control, and that all are working out their own salvation in these challenging times. As a consequence, a nationally defined role for the nurse is correspondingly less

appropriate than hitherto. The report provides a snapshot of this shifting landscape, which almost certainly began to fade as soon as it was developed.

Throughout the study the English National Board's definition of competence as "The ability to perform particular activities to prescribed standards" has been used. (ENB 1993 para 6.4)

Research Questions

During the project, in a series of semi-structured interviews and focus groups, the following questions were addressed by nurse managers, practitioners and educationalists in the fields of mental health and adult nursing. GPs and members of the multidisciplinary team were also consulted:

- What are the range of competencies required by nurses currently and in the future to meet health care needs?
- Which of these competencies are required by nurses in both hospital/residential and community settings?
- Which of these competencies are unique/critical to community settings?
- Which of these competencies are unique/critical to hospital/residential settings?
- At what level of preparation should the above competencies be demonstrated - by the newly qualified staff nurse or the more experienced practitioner?
- Where might these competencies best be achieved or demonstrated in practice settings?

Identified competencies were tested for their prevalence and perceived importance for the future in two surveys sent to a total of 630 adult and mental health nurses.

Establishing the Project

The project was conducted principally in five NHS trusts and three colleges of nursing/health studies located in three geographically distinct locations which represented rural, urban and metropolitan communities. Participating in the project were two acute trusts, providing services for the physically ill and disabled from the base of a district general hospital; and the two corresponding Community and Mental Health NHS Trusts, which offer, to the same populations, health visiting, district nursing, school nursing, maternity, learning disability and mental health services. The fifth trust in the project was a 'whole district' trust providing all the above services to a defined population.

The three colleges were all, at the commencement of the project, directly managed units of their respective health authorities. During the course of the study, however, all embarked on a process designed to identify their future higher education partners. Diploma level courses were running in all three, although the stage reached by the first students at the time of commencement of the study varied from six months to three years.

In order to gain access to the eight main organisations in the study, initial contact was made with the principals of the colleges who arranged meetings between the researchers and the chief nurse advisors to the trust boards in the chosen areas. At these preliminary meetings the aims of the project were explained and the implications of involvement discussed. Permission for access was readily given in all organisations. In one trust the almost immediate subsequent departure from office of the executive nurse necessitated a renegotiation of access, and again, this was accomplished with maximum speed and good will. There was a recognition in all of the trusts approached of the considerable benefits of the project and all welcomed the opportunity to participate. In each organisation a link person was identified and an undertaking given that the access agreement should be cascaded to all managers. It became obvious that this had occurred with commendable thoroughness in all participating organisations for, during the course of the project, no manager failed to recognise the reasons for the presence of the research team and no opposition was encountered to approaches to staff.

We cannot sufficiently express our thanks to all in these organisations who not only gave of their time in responding to the demands of the data collection techniques, but also donated space and administrative time to ensuring that our visits were used to maximum effect and our creature comforts met.

The study approached the examination of competence by adopting methodological and data source triangulation to increase the validity of data. Four approaches to the collection of data were employed, embracing both qualitative and quantitative paradigms. Initially, a wide ranging review of the literature was conducted. Then semi-structured interviews and focus groups involving diverse professionals elicited a wealth of data concerning the present and future role of the nurse in a context of multidisciplinary care delivery. Finally a survey tested key statements of competence for prevalence and future importance.

The term 'triangulation' is derived from navigation. The locus of a traveller's position in relation to one landmark is a line. To locate a precise position on a map it is necessary to fix on two landmarks, the locus then being the point at which the lines cross. In social research total reliance on one method of data collection may raise questions about the strength of that method. In reaching an understanding of the world (in this case of health care) greater confidence can be assumed if the same conclusions can be drawn from data derived from different techniques and from a variety perspectives. According to Walker (1989):

> "Triangulation can add qualification to research that would otherwise be accepted uncritically ... and (methods) can also complement each other when the survey provides a context for the qualitative work which in turn permits commentary on the survey findings" (p16)

However, critics of the adoption of triangulation techniques argue that it assumes a positivist perspective. The search for validity implies that there is indeed an immutable truth to be uncovered whose existence is independent of individual interpretation (May, 1993). Certainly the research team concur with Hammersley and Atkinson's (1983) view that a naively optimistic view of the process is inappropriate:

> "The aggregation of data from different sources will [not] unproblematically add up to produce a more complete picture." (p 199)

The decision to mix qualitative and quantitative methods may raise purist eyebrows. Davies et al's (1985) philosophy of eclecticism is one with which the study approach identifies:

> "... methods *qua* techniques do not belong monopolistically to anyone. At root, what researchers do is extraordinarily simple: we look, ask and read. The organised form of these activities which we encounter within 'Methods' books ... should not cause us to forget that observation, interviews, questionnaires ... are neither inherently qualitative or quantitative. All quantification involves judgement as to qualities and all qualitative statements invoke hierarchy, number and amount to give shape to meaning." (p 290)

Methodological Rationale

A **review of the literature** offers access to a strategy and policy framework and a theoretical perspective within which the findings of an empirical study can be interpreted. The researcher can find in the world of literature an overview of the context in which the research is set, and can highlight the key areas of tension which may be explored in the study. Given

the pace of change highlighted by respondents in this study, however, and the normal time lapse between writing and publication, material from published texts was constantly checked against news of developments published in journals. Whilst the literature review was constantly updated throughout the life of the study, an attempt has been made to avoid superimposing the wisdom of 1995 on data collected in 1994.

Semi structured interviews combine the strengths of the unstructured interview, which allows freedom to follow up pertinent issues raised by the respondent, with those of the structured interview which is designed to ensure comparability of data. The interview offers face to face contact between researcher and respondent which increases compliance with the study and for these reasons was chosen as the best method of eliciting the views of nurse managers, GPs and community nurses.

The **focus group** (Krueger, 1988; Morgan, 1988) was a potent tool used in market research for many years before being incorporated into the body of social research methods. Its basic premise is that individuals neither form nor hold opinions in isolation. The strength of the method is that it provides the opportunity to observe a large amount of interaction on a given topic in a limited period of time. Once assembled participants are allowed to explore a topic in their own words, prompted only by a few trigger questions. If the model of minimum moderator involvement is adopted, as it was in this case, the locus of control of the discussion shifts from researcher to respondent. It is thus an excellent foil for the semi-structured interview whose main weakness is its susceptibility to interviewer and respondent bias.

Finally **the survey** permits the quantitative testing of the support for assertions made by individual respondents. Much of the criticism focusing on the validity (or lack of it) of quantitative instruments centres on the deductive nature of hypotheses. Any quantitative exercise which alone aims to provide a snapshot picture of a phenomenon or concept runs the risk of relying too heavily on the central premise of all scientific or positivistic traditions, namely that the "major goal of scientific research is to establish causal laws that enable us to predict and explain scientific phenomena" (Labowitz and Hagerdorn 1971). Whilst this is legitimate in relation to the physical world, the subtle complexities of the social world require a different approach. The concept of competence is, relatively speaking, in its infancy in terms of critical examination, empirical evaluation and theoretical complexity; and the understanding of the causative mechanisms underpinning it is open to development. The items included in the survey were all generated from an intensive qualitative approach which adopted as its central premise the need to reflect accurately the views and perceptions of respondents. In this sense they can be considered "grounded" inasmuch as the questions that are being examined originate from an analysis of the social world constructed within a "sympathetic" paradigm.

Phase 1 - Literature Review and Interviews with Trust and College Managers.

The primary objective of this part of the project was to compare and contrast the vision of future care provision as espoused by politicians and the profession's statutory bodies with that of managers charged with delivering the nursing service. This was addressed by reviewing the literature relating to nursing policy, strategy, theory and practice in relation to adult and mental health nursing and, in parallel, conducting eighty three semi-structured interviews with nurse managers in the participating organisations. The research team interviewed all senior nurse managers and a 'diagonal slice' of middle and ward managers in the five participating trusts. College principals, senior education managers and a cross section of education staff were also interviewed. The choice of interviewees was, in the first instance, determined by the construction of a sampling frame which specified the managerial level and area of responsibility of the managers to be interviewed. (A complete list of those interviewed by job title can be found at appendix a). The opportunity was taken to interview, in addition to those who complied with the matrix criteria, individual ward managers whose management unit or practice was commended to us as representative of the cutting edge of developments. In this way the researchers sought to develop an understanding of the knowledge, skills and personal attributes required of those nurses whose roles were identified by managers as providing a template for the future. The number of managers interviewed who represented hospital, community, adult and mental health nursing reflected college and trust structures. Thus adult nursing services were represented by the senior managers of the acute trusts, but also by those managers in community and mental health trusts responsible for health visiting, school nursing, district nursing and community hospitals. By virtue of the seniority of the position of many interviewed, their sphere of responsibility spanned the hospital/community and adult/mental health divides.

Respondents were asked (appendix b) how they envisaged the service changing over the next five to ten years, and how in the light of these changes the role of the nurse would change within the context of multidisciplinary health care. Educational implications were also explored. Data derived from these interviews offered a five to ten year view of expected service developments and the implications of these for nursing and nurse education.

Phase 2 - Focus Groups with Practising Nurses

The purpose of the second phase of the project was to consult adult and mental health nurses as to their current role and practice. Twenty-one focus groups were held in total; seven in each geographical area. Each group was homogeneous in relation to discipline (adult, mental health), and setting (hospital, community, education). Staff lists were obtained from all but one of the trusts and a total of 240 staff were then selected for the groups using a random number table (Babbie, 1989). The fifth trust chose not to release the staff list for reasons of confidentiality. Instead the researchers provided trust personnel staff with the

random numbers and the trust provided the researchers with the corresponding names and contact addresses. Twenty participants were invited to attend each group in the expectation of a fifty percent response (Lankshear, 1993.) This phase of the project concentrated on defining in some detail the changing competencies required of nurses in hospital and community settings. Trigger questions are set out in appendix c.

Qualitative Data Analysis

Each interview or focus group was tape recorded and subsequently transcribed. The data derived were then interrogated from two discrete perspectives. First of all, content analysis was carried out and key themes and sub-themes identified and analysed. This work was carried out independently by two researchers, and was subsequently validated by two senior colleagues external to the research team before the final coding frame was adopted. The findings are presented in the following pages. Chapter 3 describes changes in the context and organisation of care, and sets out some of the political imperatives and market tensions described by trust managers and practitioners. Chapter 4 describes the changing care provision for those with mental health needs, and the impact of these changes on the nurses who work within this service. Chapter 5 reflects similarly on adult nursing services.

The second level of analysis related to the distillation of specific statements of competence as identified by the respondents. These, some 600 in all, were rendered down to a total of 168 (60 core, 61 adult and 47 mental health) by the use of the following criteria of which the selected competencies had to fulfil just one:

- represented a change in the role of the nurse;
- were perceived as assuming increased importance for the role of the nurse;
- discriminated between nursing in hospital and community settings.

From these competency statements two lists were compiled, one relating to mental health and one to adult nursing. These were presented to expert panels composed of a cross section of appropriately qualified managers and educators in trusts local to the research team. With minor amendments to the mental health list, and none to the adult, the competency statements were approved as both contemporary and valid. The statements were organised into two questionnaires which were then piloted and adopted (questionnaires at appendices d and e).

Phase 3 - The Survey

The two questionnaires relating respectively to adult and mental health nursing were distributed to a total of 630 nurses. A breakdown of the sample can be found in Table 1 of Chapter 9. The survey allowed a testing of the generalisability (Lincoln and Guba, 1985) of the competence statements and also sought to identify placement areas in which students might most reasonably be expected to achieve the identified competencies. The questionnaires were piloted using a sample of 85 nurses (13% of the total sample) drawn from the

sampling frame. Sixty-five questionnaires were returned giving a likely response rate in the sample as a whole of approximately 76%.

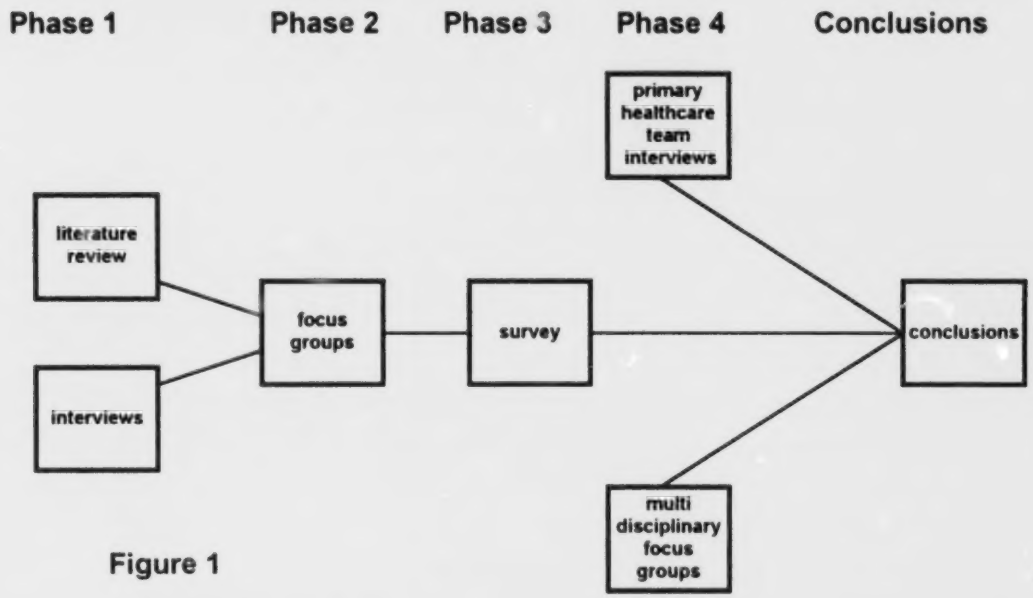

Figure 1

Phases of the Project

The Sample Plan

The potential respondents for the two postal questionnaires (one for mental health and one for adult nurses), were selected from the population of grades D-H in three geographical areas. Mental health and adult nurses were randomly selected by use of numerical tables from the staff lists of the five NHS trusts. This exercise was undertaken by the research team themselves in all but one trust, where for reasons of confidentiality the random numbers were applied to staff lists by members of the trust's personnel department. Practice nurses working in general practice were randomly selected by computer from staff lists provided by the executive nurses of the family health services authorities. The national picture of nurses working in the NHS demonstrates that the relationship of grades D-E:F-G are represented approximately by a 60%:40% relationship (DoH 1994b). As far as practicalities would allow the research team sought to reflect this balance in the sample from each clinical directorate or care context. In situations where this could not be achieved (eg community staff showing higher grade mix patterns) role and function or care context overruled the grade criteria.

A total of 585 adult and mental health practitioners and 45 practice nurses were included in the sampling plan, bringing the total number of potential respondents to 630. Details of the response breakdown and analysis of the survey results are given in Chapter 9.

Phase 4 Primary Health and Multidisciplinary Perspectives

In the spring of 1995, the research team, in consultation with the project steering group, recommended a revision to the original project specification. Having elicited from nurses their views relating to membership of the multidisciplinary team it was agreed that the perspectives of the other professionals concerned should be sought and incorporated in the study. For reasons outlined above, focus groups were chosen as the most efficient and effective method. (Topic guides at appendix f.) Representatives of the following professions were invited to these groups:

speech & language therapy	dietetics	pharmacy	radiology
physiotherapy	psychiatry	social work	psychology
occupational therapy	medicine	audiology	podiatry

The data, analysed as described above, were combined with the interview and previous focus group data concerning the role of the nurse in the multidisciplinary team and the report is presented in Chapter 7.

Finally, the research team conducted interviews (topic guide at appendix g) with a small sample of GP fundholders and their employed and attached nurses. A number of GP practices were identified in the three geographical areas and six GPs along with eighteen of their practice nurses, attached health visitors and district nurses agreed to participate. Owing to a high number of refusals to participate, attributed to pressure of work and overload of requests to participate in research, it must be assumed that a high degree of self selection was operating in the final sample of GPs. The findings are recorded in Chapter 6 .

Given the broad scope of the study, it was deemed necessary to confine this chapter to an overview which would set the study within an historical and political context. Subsequent chapters are introduced by an additional short review of relevant literature.

Competence at the point of Nursing Registration

As writers in the field agree (Black and Wolf, 1991; Care Sector Consortium, 1993; Phillips et al, 1994) a clear understanding of the concept of competence is problematical. The term covers a continuum from the lay definition of "ability to do a job" to that adopted by the National Council for Vocational Qualifications as "the ability to transfer skills and knowledge to new situations within the occupational arena." O'Hagan (1996) points out that the word derives from the Latin "*competens*," meaning to be fit, proper or qualified (Oxford Library of Words and Phrases) and Eraut (1995) highlights the "useful distinction" in American literature between competence and competency:

> "competence ... is given a generic or holistic meaning and refers to a person's overall capacity, and the term competency ... refers to specific capabilities." (p179)

He adds, however:

> "... even the word competency can be used either in a direct, performance related sense ... or simply to describe any piece of knowledge or skill which might be construed as relevant" (p179)

Competence in nursing is normally assumed to be the end point of pre-registration training. Yet Benner (1984), who sought to define the range of clinical nursing expertise from the rule bound "novice" through "competent practitioner" to the intuitive "expert," recognised that:

> "... any nurse entering a clinical setting where she or he has no experience with the patient population may be limited to the novice level of performance." (p21)

This point represents a dilemma for the present study. Managers were invited to discuss the changing competencies required of nurses working in hospital/residential and community settings. In the light of the aspirations that graduates of Project 2000 courses should be:

> "...competent to assess the need for care, to provide that care, to monitor and evaluate care and to do all this in a range of institutional and non-institutional settings," (UKCC 1986 p 40)

and the equally valid recognition that nurses working in the community are specialist practitioners, it will be seen that difficulties arise in deciding the extent of competence required in community settings at the point of registration.

Inevitably, a consideration of competence must take cognisance of the fact that the concept is only as robust as the assessment mechanisms in use. Whilst it is beyond the scope of this study to explore this area, it is pertinent to make reference to the concerns expressed in the study commissioned by the English National Board (the ACE report, Phillips et al, 1994) which resulted in the introduction of significant changes to the requirements for the assessment of practice. More recently, a report published by the National Board for Scotland points out that the format adopted for the assessment of practice is frequently divorced from the curriculum model in use. Thus the assessment of work based competence is in danger of being divorced from the knowledge which is assumed to underpin it. The latter report points out that:

> "Fitness to practise goes beyond the determination of adequacy of knowledge or skill acquisition. It delves far more deeply into the realm of determining effectiveness as a practitioner. Competence is limited to assessments of cognitive, psychosocial and psychomotor skills. Fitness to practise incorporates the murky area of 'suitability'." (NBS, 1986 p 5)

We return to a consideration of competence and occupational standards in the final section of this chapter.

The Changing Role and Competencies of the Nurse

Any discussion of nursing competence must take cognisance of the broad context of changes in health care management and delivery. Since the introduction of the NHS and Community Care Act (HMSO 1990), the organisation and management of care delivery systems have been the subject of almost constant review and change. The traditional pattern of care is slowly being eroded by social, economic and demographic change, increased public expectation, technological innovation, ethical challenges and new policies (NHSME, 1993b). Whilst health authorities and NHS trusts juggle with the demands for increased efficiency, effectiveness and patient-centredness; local authorities have been tasked with an increased responsibility towards supporting frail, elderly and disabled people in the community within a flexible and collaborative framework. The net effect has been the re-definition of some aspects of "health care" as "social care" and the trend has been marked by a rising expectation that clients will bear an increasing financial responsibility.

The nursing, midwifery and health visiting contribution to the NHS agenda was clearly set out in the NHS Management Executive publication "A Vision for the Future" (NHSME, 1993a). Building on the work of "The Strategy for Nursing" (DoH, 1989a), this policy statement recognised the central position of nurses in the achievement of future goals for health care and placed particular emphasis on the importance of a flexible, knowledgeable and skilful response to meet the needs of users and carers in partnership with other professionals. Muir, Prophit and Clark (1992) cited the Scottish

National Nursing and Midwifery Consultative Committee in a consideration of the distinguishing features of professional nursing as opposed to lay practice. One of the clearly identified functions is "the effective and efficient management and organisation of resources of personnel, equipment and services, directly controlled by the nurse" (ibid p 29). Other aspects of the professional nurse's role and function are perceived as "standard setting, nurse audit and clinical audit" (ibid p 29).

The "Scope of Professional Practice" (UKCC, 1992b) emphasised the professional accountability of the nurse and placed in the hands of individual practitioners decisions about the boundaries. In an article written at the time, the chief nursing officer (Moores 1992), stated that its six principles would enable nurses to demolish artificial and unhelpful barriers to their practice. It was believed that the document would also give new impetus to the review of how nurses, midwives and health visitors might improve the quality of patient care in the light of the publication and implementation of "Doctors in Training: A New Deal" (DoH 1991b) which tasked NHS trusts with reducing the hours worked by junior doctors initially to 83 hours per week, but by December 1994 to 56 hours "for doctors working on full shifts." Whilst a variety of solutions have since been offered and adopted, the majority of regions saw nurses as key contributors. In addition to this key driver for change, Newchurch Management Consultants (1993), in the first of a series of health briefing papers considering the impact of the government's health reforms, identified the following forces driving change in acute hospital settings:

- rapid growth in day surgery
- introduction of minimally invasive surgical techniques
- increase in programmed diagnostics
- decline in lengths of hospital stay
- shift to out-patient patterns of care."

(Newchurch Management Consultants 1993, p4)

According to Wainwright (1994) there are two ways of recognising the increasing responsibility of the nurse - role extension and role expansion. **Role extension** refers to the mechanical addition of tasks to the role (Wainwright, 1994) which were often delegated from other occupational groups, were related mostly to technical tasks (Greenhalgh, 1994) and were not covered in basic training (Rowden, 1987.) Greenhalgh and Company (1994), in the report of a study commissioned by the Department of Health, examined a total of 29 activities which accounted for up to a quarter of junior doctors' time and concluded that nurses could perform at least sixteen of these with "no significant difference in quality" (ibid p 104). If nurses and doctors shared these duties, it suggests, this would improve communication and planning and reduce unnecessary duplication in record keeping. The report went on to recommend that at least six activities traditionally undertaken by junior doctors should in future become part of the normal nursing role and should be incorporated into pre-registration

education. These activities were listed as: taking a patient's history, venous blood sampling, insertion of a peripheral IV cannula, IV drug administration, referring a patient for investigations and writing discharge letters (ibid p 109). In 1992, the UKCC (1992b) rejected as no longer suitable the notion that role extension required official sanction by certificate.

The **expanded role** of the nurse, on the other hand, according to McFarlane (1980); Pearson (1983) and Orlando (1987) recognises the value of nursing as a therapeutic activity, utilising the specialised talents and skills of the nurse. Wainwright (1994) considers the key to expanded practice to be autonomy: the ability of nurses to act on their own initiative to improve practice for the benefit of patients. The UKCC (1992b) has established principles upon which adjustments to the scope of practice should be based. Nurses are reminded that the focus of their work lies in meeting the needs of patients in an unfragmented way. The professional nurse must deliver care safely, ethically and within the scope of the individual's practice, and this care, for which the nurse is accountable, must not be inappropriately delegated.

One key area in which an expansion of the nurse has been seen is in Accident and Emergency departments, described as being on the front line of the battle between primary and secondary care. One of the options of a triage nurse in A&E is to assign patients for treatment of minor ailments and injuries to other nurses who may treat and discharge the patient without the involvement of a doctor. According to the Audit Commission report (Audit Commission, 1996)

> "All nurse practitioners should be able to *request* certain types of X-rays. There are now moves in some A&E departments to authorise them also to *interpret* these X-rays and, if their protocols allow, to treat accordingly ... Consideration should also be given to empowering nurse practitioners in A&E departments to dispense a limited number of drugs, including certain painkillers, without seeking the specific authority of a doctor." (Box F p 25)

The report of the Heathrow Debate (DoH 1994c) produced by the UK's four Chief Nurses commented that new roles for nurses may prove difficult given the public's perception of the nurse, if, for example, the nurse becomes care manager rather care provider. However the report says that "in reality there is likely to be a reallocation of tasks" (p12) between nurses and other professionals. Fear remains in medical and nursing circles about the real collaborative nature of the sharing of roles, as predicted by the Chief Nurses and recommended by the Greenhalgh Report (1994). However Brooking (1991) takes the view that all health professionals have a responsibility to consider collectively how best to respond to the changing demands of health care.

> "For economic reason, all other things being equal, there should always be a tendency to push work down to the health professional who can perform it most cheaply." (Brooking, 1991; p26)

The final comment within this section is derived from the SCHARR report "Catching the Tide" (Read, 1995) which explored in depth the interface between medicine and nursing and concluded:

> "There is no doubt that the expansion of nursing roles at the interface with medicine is seen to be advantageous to patients and both professions, provided that proper safeguards, educational provision and staff support are in place. Such role developments are certainly compatible with the needs and values of the NHS as a whole ... the alternative to taking the current and setting sail is to be left in a backwater. (Read, 1995 p50)

Adult Nursing in Community Settings

The NHSE paper, "New World New Opportunities (NHSE 1993b), recognised that Primary Health care was at the forefront of a health service revolution. According to the then current Department of Health (1990 figures), 50,000 whole time equivalent nurses were working in primary care. They were listed as: "district nurses, health visitors, school nurses, practice nurses and community psychiatric nurses" (NHSE 1993b, p10.) Three years later, Atkin et al (1993) reported that practice nurses accounted for 20% of this number (p 1).

It is the view of many involved in primary health care (Andrews 1991, Luker & Orr 1992) that community nursing is more than hospital nursing practised in a community setting, but uniquely demands a range of clinical, public health and teaching expertise. Indeed Andrews (1991) states that primary health care includes all health care that occurs outside hospital and is the principle vehicle for the provision of preventive, curative, rehabilitative and support services. Whilst care at home is far from being a recent concept, the introduction of such contemporary developments as the Peterborough "hospital at home" scheme have excited national interest. An evaluation of the scheme (Knowelden et al, 1991) revealed that by far the greatest number of patients referred to the scheme were the terminally ill and those who had suffered a CVA. It was however noted that towards the latter part of the study, an increasing number of early post operative discharge (EPOD) patients were being admitted to the scheme. It is tempting, as Marks (1991) suggests, for policy makers to underestimate or ignore the social, psychological and financial burden on patients and their families when care is shifted to the home setting. Where intensive levels of care for people with acute and possibly life threatening conditions are concerned the demands become proportionately higher.

David (1992) suggests, in addition to operating at the level of an individual, that community nurses should be able to identify the major health problems and health needs of a community, and develop health promotion and prevention programmes to ameliorate these. Community nurses must also be able to evaluate the nursing service in terms of patient outcomes and health gain. McMurray (1990) describes the community nurse as an agent of change whose care giving at primary, secondary and tertiary levels is guided by four concepts of practice, namely: promotion of health and preservation of function; prevention of illness; rehabilitation and the amelioration of illness and its effects. Whilst these principles guide the practice of many nurses working in institutional settings, there are several significant aspects in which the role of the nurse in the community differs. The engagement of many with some client groups who would not usually define themselves as ill leads to a community focus on 'wellness'. In hospital, nursing care revolves around the illness episode and is usually brief; in the community the nurse-client relationship may be ongoing, rather than episodic. The role boundaries of the community nurse are much less distinct and have traditionally demanded a generalist rather than a specialist function. Andrews (1991) asserts that there is an urgent need for the recognition of the distinguishing features of the competencies required of nurses working in the primary care setting. She identifies these features as:

"
- The need to be pro-active in meeting the changing demands presented by the variety of settings encountered in daily practice.
- The need to actively engage individuals, families and communities in their own care.
- The skill of establishing networks for collaboration and co-operation between large numbers of agencies and individuals concerned with promoting and providing effective primary health care.
- Understanding autonomy in practice and the responsibility this entails for maintaining and developing competence." (Andrews 1991 pp 15-16)

The introduction of GP fundholding and its impact on the role and competencies required of nurses working in primary care is explored at the commencement of Chapter 6. Whilst district nurses and practice nurses have a clear role in the new NHS, health visiting has come under critical scrutiny as a service unable to demonstrate its (cost) effectiveness:

> "Much of the nature and purpose of health visiting is currently expressed as an untestable assertion. If such assertions contained any truth it is defined so that it cannot be confirmed independently, and is inaccessible to all but a few priviledged individuals .. who exclusively own some elusive, intangible and invisible source of knowledge and skill." (Roberts et al, 1996)

The Nurse Practitioner

The nurse practitioner movement grew to prominence in the USA during the 1970s , originally in response to a shortage of doctors providing primary health care in rural areas. The role has developed and grown further over the last decade and may be

described as a nurse acting as an autonomous independent care worker whose practice is based on agreed theoretical frameworks.

Trnobranski (1994) suggests that an examination of the nurse practitioner role might provide a means of re-defining the role of community nurses. Certainly, in the "Future of Professional Practice" (UKCC 1994a) Council describes the need for flexible community practitioners whose practice can expand and change to meet new requirements. In the standards for General Practice nursing can be found a learning outcome inconceivable a decade ago:

> "...assess diagnose and treat specific diseases in accordance with agreed medical/nursing protocols." (UKCC 1994a; para 102.2)

Pioneers of the development of nurse practitioners in Britain include Stilwell (1988) and Burke Masters (1986.) In Fawcett-Henesy's (1991) review of the international literature, seven common characteristics of the Nurse Practitioner are identified:

- Direct/primary access to the nurse
- Choice for patients
- Authority for referral
- More personal attention during consultation
- Time
- Counselling and health education
- Diagnostic and prescribing powers for practitioners"

(Fawcett-Henesy 1991 p48)

In 1994 the healthcare division of Touche Ross published an evaluation of the introduction of nurse practitioners in 20 pilot sites. The report used Bliss and Cohen's (1977) definition of Nurse Practitioners as:

> "nurses with additional knowledge, skills and attitudes, with responsibility for assessment and treatment in primary care" (Touche Ross 1994 p1)

It concluded that the nurses studied were able to practice safely and effectively and recorded a high degree of patient satisfaction. This finding upheld those of Paykel and Griffiths (1983), Stilwell (1988) and Marsh and Dawes (1995) - all studies in which patient satisfaction and nurse performance are positively reviewed.

It is evident in the literature that, where the choice is available, many patients choose to see the nurse for counselling, social and emotional support as well as for health information (Drury et al 1988). Patterson (1993) comments that the role of the practice nurse has developed only in line with the implementation of general practitioner fundholder contracts and this is further explored in Chapter 6.

A key skill of the Nurse Practitioner, now enshrined in the core competencies of specialist community practitioners is that of prescribing, originally proposed in the Cumberlege Report (DHSS, 1986b.) The legislative framework was introduced in the United Kingdom in October 1994 (HMSO, 1992; 1994). Despite this, prescribing by

nurses is currently limited explicitly to appropriately qualified and prepared practitioners working in pilot sites in England.

Contemporary Mental Health Nursing

In seeking to identify from existing data the likely competencies required by contemporary mental health nurses in institutional and community settings, it is pertinent to note that specific mention of competencies is relatively rare. Relevant literature tends rather to focus on the mental health nursing role and skills. This material will therefore be examined with a view to identifying competencies by inference. A further difficulty in attempting to identify specific competencies within the specialism is perhaps derived from certain indeterminate features of the role. Martin cites Taylor (1982) who suggests:

> "The therapeutic role of the psychiatric nurse cannot be described in terms of tasks or procedures. It must be discussed in terms of attitudes, feelings, understanding and relationships." (cited by Martin, 1987 p9)

Carpenter and Turnbull (1991) support such a view stating:

> "Although it is clear that the mental health nurse is to some extent concerned with practical physical aspects of care, we could argue that this part of her work is not the most significant. In addition to doing certain things, all nurses are also required to be certain things, for example, understanding, patient, supportive, comforting and so on. In caring for clients with mental health problems, these 'being things' are often more important than the 'doing things." (Carpenter and Turnbull, 1991 p12).

If such views are to be accepted, the task of mapping the competencies required by mental health nurses in community and institutional settings is made difficult in that identification of indeterminate nursing qualities in either location is inherently problematic. A further confounding influence is generated by the fact that the community - institution division is but one of many within the broader profession. As Cormack states:

> "When outlining the role of the psychiatric nurse, many writers fail to acknowledge the differences which exist between the many settings where psychiatric nursing takes place ... It seems unlikely that the role of the nurse will be the same in all those settings." (Cormack, 1976 p16)

The CPNA National Survey (White, 1990) seems to support this point in reporting the diversity of community mental health involvement by nurses. Specialities identified include forensic psychiatry, sexual health in relation to AIDS/HIV, elderly care, substance abuse, rehabilitation, and child and adolescent work. Similar specialisms exist in hospital-based mental health nursing. It seems sensible to acknowledge therefore that specialisms within mental health nursing are likely to demand certain speciality-specific competencies. Nevertheless it seems equally likely to be the case that nurses broadly operating in either the hospital or community setting might require

different competency profiles to meet the differing demands of location. Some competencies may be generic, but some are likely to be context specific.

Despite such potential difficulties, as mental health nursing emerged as a profession distinct from its adult nursing counterpart, different authors sought to identify the foundations and features of its practice which at that time largely took place in the hospital setting. Towell (1975) explored the role requirements of nurses working with different client groups in hospital. Acute ward nurses were seen to be primarily involved in patient management and in acting as a communication link between client and doctor. Social interaction rather than psychotherapy characterised the nurse-patient relationship. On elderly care wards the role involved the delivery of physical rather than psychological care, whereas nurses employed in the therapeutic community setting spent their time interacting with clients in groups and meetings utilising the requisite associated skills. Cormack (1976) in reviewing both the British and American literature on the role of the psychiatric nurse cited the WHO Seminar (1957) which suggested the nurse's function could be viewed as multi-dimensional incorporating technical, interpersonal and social skills. Technical skills were seen as those required to deliver direct physical care to individual patients, interpersonal skills concerned the relationship between the nurse and the patient on a daily contact basis, and social skills were defined as pertaining to group rather than individual management. The multi-dimensional view was shared by others such as Manfreda (1964) who nevertheless identified further facets to the psychiatric nursing role including the nurse as psychotherapist, manager, socialising agent and teacher. Cormack's (1976) own fieldwork in fact suggested that the focus of the psychiatric nurse's work largely involved monitoring patient progress and offering a warm, friendly, cheerful, sympathetic, understanding, kind and non-judgmental approach rather than playing an active role in sophisticated forms of psychotherapy.

Prior to the publication of Working in Partnership (DoH, 1994a), the most recent national, government-sponsored review of the role of the psychiatric nurse in England and Wales appeared as Psychiatric Nursing Today and Tomorrow (MoH, 1968). The document described the 'elements of psychiatric nursing' which were comprised of 'personal relations', 'psychological treatment', 'bedside nursing', 'technical and physical treatment', 'social activity, occupation and recreation', 'observation', 'communication' and 'organisation', yet fell short of identifying specific competencies and also suggested that 'there is no simple formula by which to describe the work of the psychiatric nurse' (ibid, p14). Although it acknowledged the trend towards community care, the report seemed to assume a continuation of the institution (whether it be the old Victorian asylums, or the new psychiatric units attached to general hospitals) as the prime location for psychiatric nursing practice. Additionally, some of duties which were

seen to comprise collectively the 'elements of psychiatric nursing' appeared to assume a client-group experiencing protracted care in a protective environment. For example the document suggests that :

> "The nurse shares her working life with patients, and learns to accept them as they are, and to tolerate eccentricities and also personal abuse, often a symptom of a disease... The psychiatric nurse is therefore adaptable and versatile, ready, for example, to encourage and to organise patients' activities in such diverse fields as sport, music, millinery, camping or car maintenance"
>
> (ibid, p14).

Other attempts to define the constituents of hospital-based mental health nursing included Cormack's (1983) study which categorises and analyses 4,477 mental health nursing interactions within a framework which sees the nursing role as sociotherapeutic, psychotherapeutic, administrative/ bureaucratic and supportive to the psychiatrist. Bunch (1985) outlines the requirements of mental health nurses caring for those with acute schizophrenia in the hospital/residential context suggesting that they should show sensitivity and tolerance and be skilled at observing, anticipating, forestalling, medicating, secluding, communicating and risk-taking. The 1982 Registered Mental Nursing Syllabus (ENB, 1982) aimed to provide a relevant preparation for the mental health nurse to enable practice in the hospital or community setting. Competencies were addressed in terms of nursing skills underpinned by a supportive knowledge base with a recognition of the need for appropriate attitudes. Martin (1987) identifies twelve dimensions to the mental health nurse's role, namely:

"

- resource person (obtains expertise from other disciplines when appropriate)
- leader
- primary prevention
- role model (for nursing students and clients)
- counsellor (promotes personal growth of self and client)
- facilitator
- teacher
- technician
- researcher,
- mother surrogate (sustains the client by providing support)
- socialising agent (interacts and participates in patient's activities)
- manager (ensuring that the patient's personal and environmental needs are met through communication, liaison and delegation). "

(Martin 1987, p8)

Glotz et al (1994) detail a more contemporary competency-based model developed specifically to address the unique characteristics of mental health nursing as performed in the hospital setting, specifying that the nurse should show command of current theories, ethical standards, assessment, treatment planning, documentation, various therapies, medication, evaluation and aftercare planning. Carson & Sharma (1994) report staff and patient perspectives on valued mental health nursing role components in the hospital setting and include group facilitation, administration of

drugs, talking to patients, participating in ward rounds, and enabling social and recreational activity in their list of requisite competencies.

The growth and development of the community psychiatric nurse (CPN) role, particularly from the mid-1970s onwards, led to a corresponding proliferation of publications which strove to elaborate the characteristics of community mental health nursing care. At the end of the decade, Griffith & Mangen (1980) reviewed CPN role components which included client relapse prevention, assistance with employment and accommodation, advice and support to families in crisis, attending to client hygiene and nutrition, domiciliary treatment for those who could not or would not attend out-patient departments, co-ordinating between hospital, community and other agencies, and promoting the socialisation of clients in the community. Carr et al (1980) acknowledged the potential for the CPN role to overlap with that of the social worker, but saw it as one of consultant (to other professionals in the community), clinician (e.g., administering injections), therapist (particularly behavioural psychotherapy), assessor (of patient requirements), educator (of patients and other professionals) and manager.

Other authors later strove to elaborate the features of more focused CPN practice. For example, Paykel & Griffith (1983) studied the real and potential role of CPNs in addressing the needs of neurotic clients in follow-up out-patient clinics suggesting that they had proved effective in this work and that this was an aspect of the role worthy of development. Marks (1985) saw the CPN as nurse therapist proving effective and economic in administering behavioural psychotherapy to a neurotic client group in primary care. The RCN forum for those working with the elderly mentally ill identified the requirements of the specialist CPN in that field which included the ability to provide psychiatric assessment, counselling, family/carer support, anxiety management, medication advice and monitoring, mental health promotion and education, advocacy, inter-agency liaison and co-ordination and advising other professionals and agencies on mental health issues (RCN, 1989). At a more general level, the CPNA guidelines (Hale, 1985) on the clinical nursing responsibilities of the CPN suggested the development of competence in community orientated systematic care planning, health education and clinical supervision and also advocated that they should pay particular attention to responsibility and accountability for practice.

More contemporary analyses of the role of the CPN still seem to accept the relevance of previously valued skills and competencies. For example Gillam (1994), in comparing the role of mental health social workers and CPNs identifies competencies for the latter which include the observation of clinical signs of mental illness, monitoring and administration of drug therapy and observation for side-effects,

regulation of treatment regimes, guidance to the primary health care team on clinical management of mental illness, liaison, assessment, group work, social support and specialist therapy. Bowers & Crossling (1994) see the CPN as requiring competence in psychotherapy, first-contact assessment, networking, time and caseload management, accurate and comprehensive note-taking, and evaluation and suggest they should be familiar with contemporary treatments and the relevance of social and psychological factors to client problems. However, the new competencies required to meet the demands created by the NHS and Community Care Act of 1990 are also now evident. Dube (1994) anticipates that CPNs might act as brokers for care under the care programme approach performing a central co-ordinating role within the multi-disciplinary team. Additionally he suggests that they are likely to be involved in assessment and the formulation of plans for clients even prior to the identification of key workers and care managers. Thomas (1992) identifies key elements of the role which include the ability to maintain client safety sensitively, attending to medication (including nurse prescribing), patient education, empowerment and advocacy, the establishment of therapeutic rapport, risk assessment, decision making, planning and reviewing, and familiarity with specialist therapies. The Patients' Association (1994) provides a user perspective on the role requirements of contemporary mental health nurses. CPNs in particular are seen to require the skills of advocacy (winning resources for clients and carers and relating to patients groups and organisations) and liaison with other professionals and organisations. However, competent hospital-based primary nurses are regarded as requiring similar skills despite their different operational context.

In 1992 the DOH commissioned a review of mental health nursing. The report of this review, chaired by Professor Tony Butterworth, "Working in Partnership: A Collaborative Approach to Care" was published in 1994 and gives a useful indication of both contemporary aspects of the role and also likely future competency requirements. It confirms the value of research-based practice and embodies the principles of service-user empowerment. Mental health nurses are urged to serve as advocates for both client and carer, ensure services are responsive to needs, and provide information to users. Clinical supervision is seen as an essential component of effective practice. The review reiterates that the work of mental health nurses rests on their relationship with people who use mental health services at both macro and micro level. In addition to citing the ENB's articulation of the skills of the mental health nurse (DoH, 1994a, Annex F) it also details what is seen as the speciality's unique expertise which enables its practitioners to :

- establish a therapeutic relationship which rests in a respect for others and skilled therapeutic use of self
- sustain such relationships over time and respond flexibly to the changing needs of those with mental health problems

- construct, implement and evaluate a care programme
- provide skilled assessment, ongoing monitoring
- make risk assessments and judgements
- monitor the dosage, effects and contra indications of medication
- detect early signs of deteriorating mental health including potential self-harm and suicide risk, worsening physical conditions and potential threats to others
- prioritise work in order to respond to those most in need
- collaborate with all members of the multi-disciplinary team
- network effectively, setting appropriate boundaries to professional input
- manage the therapeutic environment, determined by a clear awareness of issues such as safety, dignity, partnership"

(DoH, 1994a p17-18)

The review anticipates that mental health nurses will collaborate with colleagues in primary care to create protocols which address the mental health needs of local communities. In addition it suggests a broader framework of primary, secondary and tertiary prevention strategies incorporating different levels of mental health nurse involvement which range from the provision of support and advice for colleagues at the primary level to active intervention and treatment in hospitals, residential facilities, day and community care at the tertiary stage (DoH, 1994a p27). In particular mental health nurses are seen as well placed to provide care and support for those with enduring mental illness. They are viewed as likely to play a central role in the implementation of the Care Programme Approach and the provision of supervised discharge with the potential to act as key workers or to offer specialist nursing skills, including risk assessment, within planned programmes of aftercare. The reprovision of services in the community is regarded as likely to create new demands on those nurses who continue to care for clients in hospitals. They will be addressing the needs of a more focused and harder-to-place group in a setting which may be increasingly denied the support and resources once available under the old institution-based system. Additionally they are likely to be involved in preparing residents to leave residential care and in preparing themselves for evolving roles within new service development. The review presents examples of new roles involving advanced mental health nursing practice such as liaison nursing with accident and emergency services and general hospitals, and also anticipates a developing role for mental health nurses in HIV/AIDS work, child and adolescent care alongside other nurses, disciplines and agencies, responding to the needs of elderly people with mental health problems, and in the fields of substance misuse and services for mentally disordered offenders. Their current limited involvement in diversionary schemes within the criminal justice system is likely to be extended. Indeed, the Butterworth review represents a timely summary of the contemporary state of mental health nursing and anticipated future developments and provides an appropriate backcloth for this particular research enterprise.

The introduction of the Care Programme Approach (DoH, 1990; North and Ritchie, 1993) was aimed at improving the adequacy of arrangements for the care and treatment for people with a severe mental illness in the community by providing "more systematic procedures for the assessment, planning and delivery of patient care." One year later, the introduction of Supervision Registers (NHSME, 1994a) was part of a "ten point plan" to improve care. The need for improvement was reinforced by the findings of the Audit Commission (1994a) who described the "failure" to provide adequate community resources, two thirds of the available funding still being allocated to the institutions.

The Mental Health (Patients in the Community) Bill received its third reading in the House of Commons in October 1995. The stricter supervised discharge procedures it outlines have been described as "impractical and unethical" in a joint report published by MIND, the British Association of Social Workers and ten other organisations. The role of CPNs in the care of clients subject to such supervision orders is currently the subject of discussions and debate.

Multidisciplinary and Inter-agency Working

The terms multidisciplinary, interprofessional, interdisciplinary and interagency are frequently used in the literature without precise definition. As a diversity of professions and disciplines operate within agencies it is possible to view both uni-professional collaboration in an inter-agency context and multiprofessional working within a single agency. The case for multidisciplinary work has been presented thus:

> "When we have a health or social need, it is rare that one profession alone is able to meet our needs. We can usually benefit from the skills and knowledge of different specialists - so long as their help is well co-ordinated"
> (Øvretveit, 1993,p.8)

This belief has long been accepted by the government as playing a vital role in the provision of services, along with a commitment to developing appropriate staff preparation:

> "It will be important to continue to develop multidisciplinary training for staff in all caring professions including the provision of joint training at both the qualifying and post qualifying stages." (DoH, 1989b, p67)

Statements such as this have been said to have provided a "trigger for closer working relations" between different professional groups (Dalrymple and Burke, 1995, p.72). Effective multidisciplinary work, however, can be difficult to achieve. The comment has been made that in the arena of inter agency working:

> "The evidence is of ad hoc joint planning, limited knowledge of the roles of different agencies involved and limited consultation between education authorities, health authorities, and social services departments. Surprisingly, therefore, guidance relating to community care does not address the factors which can impede inter professional collaboration"

(Braye and Preston-Shoot, 1994, p137)

In such contexts, it is not surprising that multidisciplinary work can be underpinned by conflict:

> "While a co-ordinated approach to policy making and service delivery is required, collaborative working relationships have been undermined by divergence, ideologies or priorities, separate training, blurred roles and responsibilities, financial constraints, competitiveness and different views on approaches to cases". (Braye and Preston-Shoot, 1994, p.137)

> "Conflicts are often embodied in the varying perspectives which derive from different therapeutic models. The classic expression of such conflicts is the difference between the medical and social models of distress, epitomised by tussles between doctors and social workers".
>
> (Kingsley and Towell, 1988, p.57)

The literature focusing on factors associated with the success, or otherwise, of multidisciplinary teams has been comprehensively considered by Ovretveit (1993). Such works have a remit to consider conceptual and practical aspects of multidisciplinary work more comprehensively than was practical for the current project. While the arguments informed our discussions and analysis we took a "rule-of-thumb" approach to definition. The terms interprofessional and multidisciplinary are taken to indicate a variety of professionals working together to a common goal. Inter-agency working suggests that common procedures are recognised and sought by the employees of one or more discrete agency.

Over the years, as the complexity of care provision has increased, and the number of professions supplementary to medicine has grown, the work of co-ordinating the contribution of different professionals has become a highly significant factor in assessing the quality of care. In the community, the problems of multidisciplinary and, in particular, inter-agency working are even more complex. Service users in the community, unlike those in hospital, are not in a place of safety under twenty-four hour supervision. The area in which these issues were first carefully scrutinised and severely criticised was that of child protection. Since the report into the death of Maria Colwell in 1972, (DHSS 1974) a series of reports into the deaths of children, known to the authorities as being in need of protection, have led to calls for better communication and closer collaboration between agencies. Following the passage of the Children Act (1989) a joint publication from the Home Office, the Department of Health, the Department of Education and Science and the Welsh Office set out new guidance on inter-agency working in the field of child protection (DoH 1991).

Since this time, the spotlight of concern has broadened to include people with enduring mental illness in the community. Whilst few would argue against the principle of "Caring for People" with a mental illness in a community setting, there are times when

a swift response to a traumatic episode is required. The key, as outlined in a series of reports (DoH, 1994a; North and Ritchie, 1993; Association of Chief Officers of Probation, 1994), is good interprofessional working. (If Moss Kanter's (1989) strategy for the creation of responsive organisations was likened to teaching giants to dance, this requirement must be the equivalent of forming a formation dancing team from a multilingual group of them). The Report of the Enquiry into the Care and Treatment of Christopher Clunis (responsible for the death of Jonathan Zito) (SW Thames RHA, 1994) led to the publication in 1994 of the Department of Health's "Draft Guidelines for Inter-Agency Working for The Care And Protection of Mentally Ill People." This is currently the subject of consultation.

Sprately and Pietroni (1994) comment that many of the tragedies of the type referred to above are, at least in part, attributable to the different histories, cultures, and foci of the three key professions of medicine, nursing and social work. Whilst their terms of reference inter-relate, their legislative frameworks, languages, values and emotional priorities are often quite different. However they take issue with the view of the cynics and pessimists. Collaboration between agencies, professionals, carers and the users of services gives to all concerned a sense of creativity which is missing when people work in isolation. Moreover, such collaboration goes some way towards recognising and even creating the multi-perspective and multi-cultural practice to which policy rhetoric can only aspire.

Copp (1987) discussed the theoretical framework of the interdisciplinary health care team, and the role of the nurse within this model and cites Challela (1979) who describes the role as

> "One in which responsibility for assessment, decision making, delivery of service and evaluation is shared among the various professionals who comprise the team. It is based on a philosophy of care as well as a structural approach. Philosophically it is a service to the client by a shared commitment to a group goal".
>
> (Challela 1979, cited by Copp 1987 p91)

It is evident that the current and developing competencies demonstrated by nurses will be highly influential in shaping the evolving multidisciplinary teams, and inevitably the reverse is also true.

Shared Learning

As the emphasis upon multi-disciplinary work has gained momentum "shared learning" has begun to emerge as a way of addressing the corresponding educational implications. The current definition of shared learning employed by the ENB is as follows:

> "...mutual learning opportunities within programmes/courses or the work place which meet the professional standards identified by the statutory bodies for

> Nursing, Midwifery and Health Visiting, the Central Council for the Education and Training in Social Work and other relevant standard setting bodies."
> (ENB, 1992b, p3)

Shared learning is one possible feature of collaboration between other practitioners in health and social care (Weinstein, 1994). Training at both qualifying and post-qualifying levels may involve nurses, social workers, occupational therapists, doctors, police, midwives and health visitors. It was the publication in 1979 of the Jay Report on learning disability nursing (DHSS, 1979) that led the government to set up a joint GNC/CCETTSW group to consider ways of introducing common elements into training for mental handicap professionals.

In 1986 the Cumberlege report (DHSS, 1986b,) argued that all first level community nurses should undergo a "core" common training course. This course would cross the boundaries of health visiting, district and school nursing (p42). The report made no mention of crossing the boundaries that existed between social workers and nurses in the community, although the comment was made that nurses were "hemmed inside their own disciplines" (ibid, p42). Cumberlege did envisage a gradual integration of community mental handicap and psychiatric nurses into the "core" community service as these nursing services improved.

Proposals for New Qualifying Training

In many ways 1986 represented a watershed in shared learning. It was the year in which renewed impetus was given to pursuing the idea of community care, via the Audit Commission's 1986 report "Making a Reality of Community Care". This made reference to the "formidable barriers to be overcome" in combating the "slow and uneven" progress towards community care (pp 64-65). It put forward arguments, on a broader scale than had Cumberlege, supporting the idea of core community skills based on shared training. Where the latter restricted itself to the intraprofessional arena, the Audit Commission's report was drafted firmly along interprofessional lines:

> "The concept of a "core" of community care skills could be developed for all those involved in community-based care based on shared training..."
>
> "The nursing profession is beginning to tackle this issue with the recent launch of Project 2000 by the UKCC ...This project recognises that training should be more flexible and should include much more time in the community as part of the common foundation programme. At present these proposals are for the nursing profession. But there could be considerable advantages (including improved value for money) in sharing some elements of basic training with other professional groups." (Audit Commission, 1986, paras 143,144)

In the chapter of the report concerned with the "radical changes needed" the normative tone of the commission becomes more urgent. Coupled with this urgency, the idea of community care as the vehicle for a review of training requirements can be clearly seen:

> "Useful though the working parties will doubtless prove, more will be required. In parallel with possible changes in the organisational framework for community care, the present staff training and qualifying arrangements should be reviewed. One possible way forward could be to extend the concept of the common foundation programme in Project 2000 to all professionals working in the community..." (Audit Commission, 1986, para 176)

The shift to community care as the dominant service model for some client groups (for example, the mentally ill, those with learning disabilities and the elderly) provided significant problems for service planners. This was particularly relevant to those wishing to staff services with practitioners who possessed the right blend of knowledge and skills for the emerging environments (Brown, 1992, pp 361-363). At the same time as the UKCC were promoting the idea of the new practitioner, CCETSW were attempting to push through a vision for social work of a three-year basic preparation. Walton argues that the rejection of CCETSW's proposals was a set back for the statutory bodies as the Qualifying Diploma in Social Work and Project 2000 were structurally compatible.

In 1988 the community care model was about to receive yet another boost from central government in the form of the Griffiths report (DHSS 1988a) on community care and the subsequent White Paper "Caring for People" (DoH et al 1989b). The former represented the initial framework for subsequent reforms, and as such was an influential policy document with regard to shared training. Griffiths argued:

> "...staff need training to fulfil their own roles, but also need to understand the contribution of other professions to community care. Insularity among individual professional groups can lead to failures of communication and inability to recognise both needs and options for meeting them. The need for effective collaboration in training matters at the local level to tackle this should be addressed by all authorities, both during the implementation period (of community care) and as an ongoing task." (DHSS 1988a, para 8.9)

Although "Caring for People" devoted an entire chapter to collaborative working little concrete detail regarding joint or shared training per se was included. The Government commented that:

> "...nurses' time is deployed to best effect on work which requires their special skills, leaving work which does not require those skills to be done by others." (DoH 1989b, para 4.18)

It was unfortunate that no attempt was made to define the skills to which this referred (Shaw, 1993, p260). A significant effect of the Government's perceived correlation between multi-disciplinary training and more appropriate nursing skill-mix is that, for the first time, training was beginning to be a feature of the move towards better "value for money". No longer a peripheral concern, training was to form part of the general restructuring of welfare that had occurred over the past fifteen years.

In 1990 the NHSME commissioned a small working group to consider the management principles which should underpin the changes likely to occur in nursing following the introduction of the NHS and Community Care Act. Their recommendations were intended to apply to the full range of community nursing services and across all community organisational structures. The group's report, "Nursing in the Community" made several references to joint training (NHSME, 1990). Interestingly the group sought to further clarify the concept of "joint" working and training in relation to nursing practice and training. One interpretation of the reasons behind this clarification is that it was necessary to address some of the age-old professional fears that social workers could encroach on health professional assessments of their clients (and hence their work). More likely, however, is the assertion that it was to clarify the role of the social worker in providing the lead in community care assessment; which was a feature of both the Griffiths report and "Caring for People".

In the discussion document "Training for Community Care: a Joint Approach" the principles expressed in "Caring for People" were expanded, into the most concrete indication to date of the form of joint training envisaged by the Government (DoH/SSI, 1991). In this report three ways were proposed in which shared training would contribute towards the aims of "Caring for People":

> "the focus of services needs to shift from being agency (supply) driven to one which is user and carer centred. Agencies will therefore need to integrate their approach and shared training is a vehicle for this."
>
> "Caring for People requires priority given to users with the greatest needs. This will mean in practice that users with complex health and social care needs will have to have these met, in a co-ordinated way, by a variety of agencies."
>
> "Common training needs of staff in different sectors can often be met most economically by shared training activities." (DoH/SSI, 1991, p4)

"Training for Community Care" was unequivocally positive about the perceived outcomes of the shared learning debate which included:

- a co-ordinated approach across statutory agencies
- appropriate involvement of users and carers
- involvement of General Practitioners and practice teams
- robust equal opportunities practice in ensuring access to and appropriateness of local services
- progress towards co-ordinated commissioning of services from a common value base
- the development of shared information systems.

However, the reality of establishing training based on the document's proposals did not produce the hoped for outcomes. In addition the DOH commissioned the NHSTA, SSI and CCETSW to supervise a seven site project on the feasibility of joint training (Carpenter, et al, 1991).

Shared Learning "on the ground"

Based on the support given to joint and shared training in "Caring for People" and the obvious Governmental will to link it to other developing service issues such as quality and value for money, it was becoming clear that joint training was gaining ground. In 1992 a circular to key "players" in health service education laid down the English National Board's and CCETSW's short-term plans and underlying principles for joint training (ENB, 1992). Shared and joint training were terms that were to be replaced with "shared learning" which was viewed as possessing particular strengths:

> "enriches the personal and professional development of participants";
> "increases the scope for collaboration and co-operation in care";
> "develops understanding between the care team";
> "increases the cost effectiveness in respect of areas relating to the development of skills common to more than one discipline";
> "enhances professional development rather than diluting it."
>
> (ENB, 1992, p2)

In contrast to the situation in the early 1980s the above sentiments addressed a wider range of professions. In 1991 CCETSW and the Royal College of Psychiatrists held a symposium around the theme of "working with people who have both learning difficulties and a mental illness". The report of the symposium drew up ten themes of training for staff working with group of service users. For the first time, the medical profession were beginning to explore the virtues of shared training in relation to one of its client groups. However, equally worthy of note is the paper's failure to mention inter-disciplinary or inter-professional training between other medical staff and nurses or social workers. It does not appear that interprofessional training at the specialist level is yet on the mainstream agenda for doctors. This restriction of the debate to the "semi-professionals" (Etzioni, 1969) can be seen in Renshaw, Jones and Andrews' (1990) description of the lessons learned from a joint approach to mental health training. They noticed that, despite being invited, neither GPs nor psychiatrists managed to attend joint training workshops although this had did not have a negative effect on the outcomes of the project:

> "The emphasis on non-medical aspects of care has been strengthened in planning and service management. The sector teams have become stronger in themselves and do not always need to look to a consultant for leadership. Links between professions such as CPNs and social workers have been developed..." (Renshaw et al, 1990, pp 18-19)

It is notable that Renshaw et al's approach to joint strategies for training included service users, voluntary sector and user-representatives. Such an approach is only now being reflected in government commissioned reports.

Despite the title of the Butterworth Review, "Working in Partnership: A Collaborative Approach to Care" and the report's broad remit, shared training or learning was a feature of just one of the recommendations out of forty two presented:

> "We recommend that education providers should collaborate with service providers to develop further cost-effective shared learning packages which meet the needs of mental health nurses, other professionals and non-professional health care workers."
>
> "With the convergence of professional education into institutes of higher education, the opportunities for shared learning and joint educational initiatives between health care professionals should increase. Appropriate shared learning will also enable more cost-effective use of resources and facilities. The development of multi-agency working in practice should also provide a stimulus for such initiatives..." (DoH, 1994a, pp 44-45)

Despite the limited amount of space in the report devoted to shared training the Governmental commitment to shared training generally, and for mental health nurses specifically, has remained. Earlier discussion of the problems associated with developing local initiatives based on Governmental intent, and then attempting to link these back to a national structure via validation, show that this process in mental health may not be altogether straightforward.

Some of the problems involved in developing a national structure from a local initiative are seen in the ENB/CCETSW/COT (College of Occupational Therapy) Joint Practice Teaching Initiative which began in 1989. It took the steering group three years to agree a core curriculum for practice teaching with the relevant statutory bodies. However, even with an agreed core module in place, a jointly validated award for practice teachers from all three professions was not considered appropriate (Brown, 1993). In "Building a Partnership" (ENB/CCETSW, 1995a) the ENB recognise:

> "... there are uncertainties about the future of shared education and training at qualifying level." (p 18)

However, in "A Good Practice Guide" which documents the outcomes of a joint ENB/CCETSW workshop held in January 1995 (ENB/CCETSW, 1995b) the advice at pre qualifying/pre registration level is to:

> "... encourage a shared understanding of the core agenda and to establish a closer working relationship which will continue following registration."

The guide goes on to recognise that changes in higher education have facilitated opportunities for shared learning yet despite the agreement in principle, the problems of cultural and organisational differences between the professions remain evident.

Occupational Standards and Competencies

At the time few recognised the future impact on the educational arena of the publication of the DeVille report in 1986 and the subsequent White Paper "Working Together - Education and Training" (DoE/DES, 1986). In an attempt to rationalise the multiplicity of vocational awards, the National Council for Vocational Qualifications (NCVQ) was proposed, and subsequently formed. Links and ladders between

vocational courses, and access to academic credit were envisaged. The innovative feature of National Vocational Qualifications (NVQs) was that they were defined not by completion of a given length of study, but by the demonstration of competence - a shift in emphasis from teaching to assessing. The statement of competence was to incorporate the assessment of skills to specified standards and the application to the performance of specified tasks. The influence of NVQs as an expression of the Government's desire for education and training which was workplace based and employer determined is a matter of record.

Ever since the NVQ framework was announced in 1986 the Government has considered all aspects of their application and introduction. Their application has been extended into secondary education with the development of the General National Vocational Qualification , first as an alternative to the traditional "A-Level" and then as a vocational stream to run parallel with the GCSE years. From the viewpoint of the professions one of the most significant developments has been the legal linking of competence-based job descriptions with issues surrounding employer liability (DTI, 1989). It is now possible, in clearly defined circumstances, for employers to use the NVQ as a possible alternative to a professional qualification. Throughout these developments the nursing profession, along with others in health and social care, has often been ambivalent. But, as recent NHS Executive letters indicate, it is no longer possible to ignore the inexorable trend towards incorporating occupational standards into nurse education and training (NHSE, 1995d).

In 1994 a report by Smithers was given extensive publicity when it was used as the basis for a Channel Four Documentary. Criticism focused upon the reductionist and mechanistic nature of the assessment of competence together with the costs involved (Smithers, 1994). Such comments and criticisms echoed points made by the CBI earlier that year (CBI, 1994). The position of central government, however, has always been clear. Publication in the following year of the white paper on "Competitiveness" indicated a strong commitment to ensuring that competence, as incorporated in the National Vocational Qualification, should work and a major review of NVQs to be completed towards the end of 1996 was announced (DTI, 1995).

In 1995 a sequence of Executive Letters from the NHSE indicated that all professions must now begin to incorporate occupational standards into their education and training programmes, using the same set of criteria that are used with National Vocational Qualifications (NHSE, 1995b). At the same time priorities identified for education commissioning explicitly incorporated shared learning:

> "Education commissioners should actively explore opportunities to commission multi-disciplinary education and training and programmes which provide opportunities for shared learning." (NHSE, 1995c, p5)

Crucially, it is necessary:

> "To secure sufficient clinical experience and supervision for students in practice placements to achieve specified learning outcomes and professional competencies." (NHSE, 1995c p6)

Difficulties associated with defining "occupational standards" and the links with "competence" are compounded when attempts are made to identify bridges between competence and credit schemes (Atkins et al, 1993; Robertson, 1994). For the purposes of this project it has not been possible to distinguish between levels except through the distinction between pre- and post- registration. At the same time it has not been possible to assess the quality of placements and actual, as distinct from hoped for, outcomes. Allowing for these caveats the definition of competence that has been adopted is that forwarded by Eraut and Cole:

> "The ability to perform to an agreed standard, a specified set of tasks, processes and functions over an agreed range of contexts and situations"
> (Eraut and Cole, 1993)

The "... tasks, processes and functions" identified by practitioners and managers at both middle and senior level, and the implications for the substance of placements at pre- and post- registration levels, provide the essential features of the map that is outlined in the following chapters.

A Time of Change

The opening paragraph of the report of the Heathrow Debate "The Challenges for Nursing and Midwifery in the 21st Century" accurately reflects the context in which the present study was conducted:

> "As we approach the end of the second millennium, the pace and scale of change can sometimes seem disorientating. Our horizons are constantly shifting, as society evolves and scientific and technological innovation offers new opportunities and challenges." (DoH 1994c p2)

Without exception, although with varying degrees of enthusiasm, respondents within the study made reference to the degree and pace of change. Many reported a significant number of changes in job title or in the definition of their responsibilities within the preceding two years. Indeed one respondent's reply to the seemingly innocuous opening invitation to describe her role and sphere of responsibilities ran to three pages of typed script, and would in many ways be worth reproducing in full as an illustration of the extent of the personal challenge inherent in the pace of management changes. Such a reproduction would, however, constitute a clear breach of confidentiality.

All of the managers interviewed referred to the "challenges" offered by the current agenda, and were keen to offer a contextual overview of the changing service in which nurses are employed and in which their views on the role and competencies of the nurse were set. These contextual issues fell within the following headings:

- The shift from hospital to community care
- The influence of purchasers
- Relationships between health service providers
- The pursuit of excellence including cost effectiveness and value for money.

The Shift from Hospital to Community Care

It was a *sine qua non* of the discussions that the shift from hospital to community care would continue in line with current national strategy. For respondents in mental health this was a continuation and culmination of a ten year strategy. In acute trusts, there was general recognition of the need to use expensive hospital care to maximum effect. The consequent reduction in hospital beds was recognised as being a necessary and acceptable part of the strategy. According to official government statistics released in April 1995, during the period 1980 - 1994 bed numbers in England reduced from 356,000 to 219,557. In the four years prior to the commencement of this study 35,992 beds were closed (White 1995 p24). All of the acute trusts in the study had contributed to this rationalisation but whether, and to what extent, the trend would continue was an

issue for debate. In the view of one senior manager the potential for further reductions had at times been overstated:

> "I think there are a lot of myths floating around about bedless hospitals, and I would put myself on record as saying they are myths ...The reason I say that is, I think a large proportion of service is emergency services, and there's no sign; nobody's able to demonstrate to me that service is going to drop off, and there's going to be any less need for beds.
> *INTERVIEWER*: What percentage of your current work is emergency?
> *RESPONDENT:* Oh hazard a guess, I mean if you took the medical and elderly division it's 90% - 95%. If you took general surgery and orthopaedics and areas like that it probably somewhere about 50/50." (Senior Manager)

Notwithstanding the above, all of the trusts in the study were considering future rationalisation of estate within a five year period, both in relation to the closure of what had been in the past, large psychiatric hospitals and, in acute trusts, the compression of in-patient facilities. Specific developments to achieve the shift in both mental health and acute services are detailed in later sections of the report, but in summary it was generally recognised that services would move closer to the people, with the development of mental health resource centres, community units for the elderly, polyclinics, hospital at home schemes and a general increase in the range of services offered within GP practices. Key features in the more efficient use of hospital beds were an expansion of day surgery services; the development of hotel and outreach services; and the dislocation of some pre-operative activities, such as assessment, from the actual in-patient stay.

With the shift in focus from hospital to community came opportunities to integrate services currently based in different hospitals and clinical directorates. Senior managers in three trusts discussed a client focused approach in which the potential for bringing together acute, mental health and learning disability services for children was recognised.

The Influence of Purchasers

Whilst the health service remains nationally funded and strategically defined, increasingly the nature and kind of service delivery is locally determined. The introduction of trust employment contracts and locally negotiated pay will hasten the end of national definitions of role, and render more fluid those of all professionals employed within the resulting federal health care service. The influence of health authority purchasing strategies was perceived within the study to be far reaching, relating to required improvements in the quality and cost-effectiveness of the service, to increases in the number of finished patient episodes, and to the definition of the role of the health visitor. Of equal, if not greater, moment was the emerging influence of fundholding general practitioners. During the course of this study, at a national level the purchasing decisions of GPs began to impact on trusts to the extent, in extreme

cases, of rendering them financially non-viable. In April 1993 the scope of the fundholding scheme was extended to include the purchase, from trusts and directly managed units, of community health services, including district nursing and health visiting. This step was supported by the strategy document "New World New Opportunities" (NHSME,1993b) which advocated such commissioning as a means of ensuring that practice populations received care geared to their needs. For a detailed account of the relationship between trusts and GPs and an analysis of the impact of the new contracts on the community nursing service, see Chapter 6.

Relationships between Service Providers.

Senior manager respondents in the study outlined the complexity of managing care provision in the context of a competitive, if managed, market involving acute and community trusts, GPs (poised to extend the range of their service provision), social services, the independent sector and charitable bodies.

As previously outlined, within the study there were two pairs of trusts, derived from single 'pre-reformation' health authorities, each providing discrete services to the same geographical population. In those two areas the transfer of care from hospital to community entailed crossing trust boundaries. All those involved recognised that it was imperative for good patient care that managers in the two types of trust worked together, and many, at all levels, paid tribute to the good relationships which existed on a day to day basis. A senior nurse manager in a community & mental health trust commented:

> "The relationship we have with the acute hospital trust I think is very good. I think we tend to underestimate how good that relationship is. I think it is particularly good at field level - at professional level." (Senior Nurse Manager)

A ward manager concurred:

> "Generally, we have quite a good relationship going. There's a district nurse who rang up this morning who hasn't got any probes, so she's coming to thieve some of ours. You've got to bend the rules a little bit, but it's the communication that's the main thing, and we find that we can ring a district nurse at any time ... we can go through the bed bureau if we need an urgent district nurse, and they'll arrange it." (Ward Manager)

There was evidence of shared working between the trusts. Consultants employed within one of the acute units, for instance, offered locality based services to patients by conducting out-patient clinics in community hospitals. National strategic initiatives and purchaser requirements were also said to act as a cohesive force. The requirement for a 5% reduction in the incidence of pressure sores was quoted by one respondent as an issue which brought representatives from acute and community services together to plan the mechanisms for recording incidence and prevalence.

A senior manager in a community mental health trust, in a discussion of the advantages and disadvantages of operating within a split trust scenario, pointed out a key positive planning and funding advantage for some client groups:

> "A number of our services are what you could classify as a Cinderella type services within the NHS. A lot of them aren't very high profile. We have learning disability and mental health and we see ourselves as advocates for those services in competition with the demand for acute services. I think if they were all grouped together there would probably be a greater chance of those services being neglected." (Senior Manager, Mental Health)

There were, however, felt to be inherent problems in the dual management arrangements. The separate business planning processes were said to mitigate against good forward planning. Whilst the two bodies received one another's completed business plans, there was little joint strategic planning, the exceptions being in specifically defined areas like child protection. Yet as a general rule it was in the area of child care as well as that of elderly care that the reality of competition appeared to interfere with shared planning. The following quotations are from two senior managers, one in a community and mental health trust and the other in the paired acute trust

> "So there is a lot of talk at the moment about who would actually lead a combined child health service as an example and obviously there is an issue of competition in terms of tendering for that potential contract then relationships can get a bit frayed." (Senior Manager Mental Health)

> "In some areas we are competitors, I mean elderly care is a good example of that. ... the four elderly care physicians have access to beds in community hospitals which are managed by the community mental health trust, and have access to beds which are managed within the acute trust, by us. The clinicians get very frustrated and clearly the nursing staff within those community hospitals are not managed by me." (Senior Manager, Acute Services)

The same manager (of an acute trust) highlighted a concern for the constraints imposed by the lack of flexibility of funding, which, he claimed, actually seemed to impede developments in community care:

> "I still I look now around at us and say well why have we got elderly wards, we shouldn't have them I don't believe, but what we should be doing is saying, right £300,000 for that ward, we'll close that, and that money goes to the community to provide alternatives, whether the community is community health or social services ... or the independent sector."
> (Senior Manager, Acute Services)

At an operational level, there were a number of problems, not the least of which was the need to keep track of equipment which was perceived as "leaking" from acute to community trusts. However, one of the most acutely felt issues, of particular relevance to this study, was that of addressing staff development issues in the changing world of health care delivery. A senior nurse in an acute trust responsible for the management of orthopaedic services commented:

> "I have very little, if any, impact, in terms of how community nurses are trained, and what their vision is. I don't know what their vision is, the community nurses, I'm sure there is one." (Senior Nurse)

This was cited as a key factor in the development of outreach services - home visits carried out by ward based nurses - and is picked up in a later chapter. Briefly, the situation exists in which an acute trust, in its drive to increase efficiency and reduce the length of stay, wishes to discharge patients with specialist nursing needs back to their homes. In order to give continuity of care, there is a perception that the community trust needs to develop a home nursing service with specialist skills in, for example, the care of patients discharged following hip replacements. This requires an investment in staff development by one trust in the interest of increasing the efficiency of the other, and to some extent rival, trust. Those who worked in the one whole district trust in the study were aware of their advantages in this area of staff development:

> "The links I think are much easier for us to establish with being a joint trust than you may find when you go to acute and community trusts. It's very easy for me to say let's do some training with the health visitors, ... whereas I think if it was a different trust it would be much harder ... and also we're not giving away business if we had our children who go into the community and our RSCN's followed them up. They'd see them on the wards otherwise, so it's not as if we're giving away business to another trust by sending children home. It's very amicable arrangement, we sit down and discuss what we're best at and that's it, it's not sort of tied up around costs and budgets and also things like training of staff. Wheeling staff in for a day's shadowing or a day's experience, if we had to pay for that it would be very different, because it's just a phone call. It's a very cost effective thing; very easy to do."
>
> (Middle Manager)

The same manager, in continuing to explore these advantages, also however sounded a note of caution:

> "I mean it's quite cosy which is very nice, but because the communication links are very easy, there's no sort of trying to prove ourselves. There's no sort of pressure in that direction, sort of push for services or compete with somebody else."
>
> (Middle Manager)

Similarly trust managers were coping with the differing philosophies of **general practitioners** to nursing assessments and care in the community. As GPs increased the range of services they offer and, as fundholders, contract for the services of community staff employed by the trusts, the clash of values was increasingly an issue. A senior manager in one trust commented:

> "When I look at the professionalism of my community nurses in undertaking assessments, and the cost of that, but the quality of that, and then I look at the fact that GP's can employ anybody ... I find that exceptionally frustrating. Some practice nurses employed by GPs have superb qualifications, are very highly trained and very highly motivated - but not all. Whereas every single district sister is a grade G and has gone through a very set criteria, and a very set training, so there should be a very clear standard, and I find that exceptionally frustrating, and it must be addressed nationally."
>
> (Senior Manager)

For the chief nurse adviser to an FHSA, addressing this issue took the form of providing access to training for practice nurses. Then the decision as to who should visit patients at home should be based on the skills available rather than on the

individual's title. The relationships between GP fundholders and trusts are further explored in chapter 6.

Relationships with the **independent sector** were discussed. The importance of the provision made within this sector for the care of the elderly was implicitly accepted by most respondents. Given the demographic changes occurring concomitantly with bed reductions, reliance on the continued development of provision by the independent and voluntary sector was high. There were expectations that the range of services offered outside the NHS would continue to grow:

> "I think there's that area that's interesting, and one of the big areas that's going to impact too, perhaps more on - well no - on community as well as on hospitals, is the independent sector... and if the current philosophies go on there's going to be a major continued growth of independent sector contribution. For instance, if it hasn't already happened it's only a matter of time before a company sets up and knocks on somebody's door and says, we will provide you a community service."

In fact, at the time of writing a controversy rages in the Grampian Region of Scotland where a capital development has been commissioned through the private finance initiative. There is a possibility that once complete, the hospital will be privately run. If this move succeeds, for the first time in Britain, responsibility for the provision of core services will be vested in the independent sector.

The role of **social services** in the provision of social care was, of course, recognised and along with this the potential for the gradual re-definition of a proportion of health care. The parameters of responsibility were in the melting pot. In the words of an acute trust manager:

> "A whole range of 'conditions', are being disenfranchised from the NHS - you know the use of language like social care. Oh that's not health, so we are not interested." (Acute Trust Manager)

In the interest of improving communications between health and social services at the highest level various strategies had been employed, particularly by the community and mental health trusts, to promote cohesive and coherent care:

> "We actually invited them into trust board meetings such as the mental health steering group; we actually have social workers on that because of the very big overlap and that has helped a lot of problems." (Senior Manager)

Nevertheless, difficulties persisted. The absence of facilities for joint strategic planning led one senior manager to remark:

> "I think to be honest that in terms of working collaboratively at developing operational policies with other agencies such as social services, we have got a long, long way to go." (Senior Manager)

In all of the geographical areas, however, interpersonal relationships "on the ground" were perceived as good, and by and large structures facilitated communication. In two

areas, however, a reorganisation within social services had resulted in a major dislocation. A senior manager's frustration was obvious:

> "The social services have, in their infinite wisdom (and I am sure they did it for a good reason) changed the way that social workers are allocated and they have got mega problems with communication." (Senior Manager)

Concern in one area was expressed at the possible effects of the boundary commission review. A senior manager responsible for child protection issues reported:

> "(It) will have a phenomenal impact if (name) County disbands and goes back into four districts, with four separate Social Services. At the moment it is county wide, so wherever you go in (name) the procedures are the same and people work basically on the same process. So I would say that's going to be the major impact on child protection services." (Senior Manager)

From the perspective of primary care, the aspiration was to have social services recognise the practice population as the primary unit of population. In envisioning the future organisation of health care over a five to ten year period, a number of respondents from the mental health services raised questions as to whether at least a proportion of the work of CPNs could be re-defined as social care and thereby be included in the remit of social services. Indeed a senior manager in a community and mental health trust suggested that this might in time become the preferred scenario.

Relationships with **charitable organisations** were also discussed. In one area the charity Age Concern was providing a service to elderly patients attending A & E, with volunteers accompanying elderly attendees through X-ray, haematology etc and taking care of domestic problems such as the abandoned pet. Trust dependence on the fund-raising activities of charities was also acknowledged, as was the group home provision of such bodies as the Schizophrenia Fellowship, and the educational role of the British Diabetic Society and the Heart Foundation. GP respondents also raised the subject of contact with charitable agencies but most of the contact was via literature and consisted of referral of patients for information.

The Pursuit of Excellence

Efficiency

It came as no surprise to the researchers that senior manager respondents made repeated reference to quality issues and in particular to the drive to become ever more efficient and to demonstrate cost effectiveness. The following quotes are taken from two senior managers responsible for acute services in two different trusts. For the first this seemed a positive motivator and was linked positively rather than negatively to other aspects of quality:

> "There is a genuine desire for us to be cost effective without reducing quality. Our Chief Executive said if he cut one of us open he'd have the word quality running right through us because it's a cultural thing within the trust."
> (Senior Manager)

"I certainly think that resources are very tight in the health service, and nurses certainly have got to understand and maximise the use of the resource."
(Senior Manager)

The pursuit of increased efficiency and cost containment leads naturally to the consideration of strategies to reduce the length of patient's stay. This is further developed in Chapter 5 in the consideration of the developments which will achieve the shift from hospital to community services. It is worth noting here that it was the single factor mentioned by all respondents from acute services.

"We need to have that (length of stay) down. We can't have people hanging around because that's costly, so it's battling all the time." (Senior Manager)

"Because there's no doubt about it, certainly in acute medicine, the turnover of patients now is such that you do need a team to be able to assess and implement, treat and evaluate, a range of care, because the turnover is so great, we need be much slicker in the way that we do it. The pressure to get people in, seen, stable and out, is massive." (Senior Manager)

There was, within the senior managers' transcripts, evidence of an explicit desire to offer patients better, streamlined services which properly value their time. However, for middle managers who were tasked with operationalising the strategies of the senior managers, the issue of cost containment was viewed less as a stimulating challenge and more as an oppressive problem, being intimately related to reduced staffing levels and the consequent difficulties of maintaining the service.

"We've got to make cost improvement programmes ... now the easiest way to do this is to keep a vacancy that will always be a nursing vacancy and so that the rest of the nursing team have got to make up ... work harder for that vacancy." (Middle Manager)

A manager within a forensic psychiatry unit considered himself fortunate:

"Well in my situation where I'm dealing with clients that are detained in a secure setting I can basically always maintain my nursing level. I've got to not just provide clinical care, but I've also got to provide the security, and if I don't provide the security it'll be a bit of a headache for the trust, in general, and the secure levels provided by the number of nurses I have on at any one time. It's slightly easier for me." (Middle Manager)

An operating department manager indicated that whilst turnover had improved, staffing was considerably reduced from the levels which pertained some years before. The pessimistic tone of this manager's view was in marked contrast to that of his more optimistic senior colleagues:

"Morale's never been lower within this department. Whether it's on the scrub side or the anaesthetic side morale is at an all time low. Talking to the ward staff at handovers they're exactly the same on the ward - short staffed and over-worked. Morale is low throughout." (Middle Manager)

One middle manager expressed the belief that the issue of cost effectiveness might put the whole community mental health nursing service at risk. Given the geographical spread of the area concerned, the amount of actual client time was relatively small and difficult to justify in terms of a cost effective service, where one

hour of client contact might have to be set alongside six hours of travel. This was particularly pertinent in specialist services such as forensic psychiatry.

> "We've actually got a review of the CPN services ongoing at the moment because we were worried about the cost of the service and the amount of client contact ... their clients may be over in other side of the country somewhere like (name). You spend six hours travelling there and back, when you only have an hour available to see a client. We're forever looking at the balance between time and the client." (Middle Manager)

The debate around efficiency and cost effectiveness led several respondents to discuss rationing. A college director commented:

> "The fact that technology and the nature of organisations is such that we are actually working technology harder, working people harder, we are employing fewer people ... and that has implications for the gross national product - and will stimulate debate about rationing." (Senior Manager, Education)

Many other respondents highlighted the need for open debate about rationing of health care services. Another senior educationalist commented:

> "I think I also expect a bigger situation of rationing. I expect the quality of life years to be an issue. I think rationing exists, but I think its ... subtle and hidden, and I think decisions will be more overt and we will be more clear about what we can expect from the health service."
>
> (Senior Manager, Education)

There was a view from the first of the above respondents that the subject had to be "outed:"

> "We can have a sensible rationing debate ... essentially there's a sort of feeling about we mustn't discuss this in front of the children. My point may be in fact we've got to discuss it in front of the children if we want to involve the electorate, there's going to be some really tough decisions to be made ... in doing it overtly rather than covertly." (Senior Manager, Education)

Inevitably, went the argument, the least contentious system of rationing in a free market society was that of introducing charges at the point of delivery. The senior educational manager quoted above went on:

> "I mean we're moving away from the notion of the NHS being an institution that takes care of you from cradle to grave ... it will increasingly arrange for others to provide for health care ... from the public to the private sector ... You and I are going to be required to essentially pay increasingly for our health care, particularly on chronic care." (Senior Manager, Education)

Patient Satisfaction

On the other hand, issues concerning the increasing accountability of nurses for the quality of the patient experience were raised. As audit increasingly embraces all aspects of the patient's experience, G grade ward sisters find themselves accountable for the standard and quality of care on their wards. The Patients Charter (DoH 1991a and 1995) and issues of patient choice were also raised, with an expectation that the sophistication of the demands will increase with time:

> "At the moment, many of them just want to talk about whether their egg was hard boiled when they asked for soft boiled. Did the nurse smile?, In five

> years time they will be wanting to know 'What type of hip replacement did you give me?', 'Was it titanium or was it copper?' And because more information is available, they'll be wanting to influence that." (Ward Manager)

Within the mental health field explicit attempts are being made to give patients a voice. In line with advice from the NHSE Mental Health Task Force (1994c and d) both purchasers and providers were actively seeking the views of users when determining the shape of service provision.

In addition, at least one trust in the study was on the point of employing two advocacy workers in order to increase the effectiveness of the patient's contribution within the care planning scenario. It was recognised that there were enormous cultural changes to be engineered within the caring professions. The acute trust senior manager who ruefully recognised that one of her problems in implementing the named nurse initiative was that nurses felt threatened by having to give their names could, undoubtedly, concur with that.

Health Care and the Professions

All agreed that the roles of all professionals engaged in health care were under scrutiny. Skills which were previously in the medical domain have been passed to ambulance paramedics and, in the pursuit of a reduction in the hours worked by junior doctors, to nursing staff and others (DoH 1991b; Greenhalgh, 1994). Many 'basic' nursing tasks have been taken up by the health care assistants who were the means by which supernumerary status for student nurses was achieved. The number and nature of health care professionals for the future was identified by some respondents as being an issue for present and future debate. One acute services manager gave as his opinion that the reductionist approach of the last few years had given way to a reappraisal of the contribution of the professional nurse:

> "I think there's discretion really there. We've got in these health care assistants, but I don't think that means that nurses don't do a lot of these things really, because I think nurses like to work very much in the principle of holistic care. They argue that they're better equipped sometimes to deal with what we've always considered mundane tasks, because they're dealing with a range of other things at the same time, and we've got all the linkages there so you know I think I'm not as hung up on that as I used to be ... In the past we analysed things. This is not appropriate for nursing, this could be handled with lower level skill. Now I'm not quite so sure. I think we've got our skill mix about right now." (Senior Manager)

A senior manager responsible for mental health services widened the debate:

> "It is not just nurses, it is where nurses fit into the whole team which is going to be the key. I can't see all the disciplines continuing separately in the next ten years. It doesn't seem to bear thinking about." (Senior Manager)

It was further recognised that flexibility was the key to survival. There are no statutory or other constraints on the role of the health care assistant. A senior educationalist expressed the following view:

> "I think that the scope of practice based on the type of knowledge that people have or can reasonably acquire will determine a lot about the boundaries of practice ... between health care practitioners ... I think the other thing that needs to happen is a real adjustment in the way in which organisations function to allow people to practice - ... to give appropriate authority to people to work in accordance with their knowledge base and to allow them to be accountable for that." (Senior Education Manager)

Powerful messages emerged from the data concerning the professional status of nursing and its contract with society. It was reported that nurses feel less secure in an economic climate where value for money is a key consideration, and yet the need to remain alert and responsive is clear and professionally recognised:

> "There's a big body of people who want to de-professionalise the health service because we are an expensive commodity, and I think this is the key issue at the moment how to cut the cost of the health service and yet improve conditions for patients. I think nurses, in their *(the manager's)* opinion are getting paid too much, we've priced ourselves out of the market. I think there will be a lot less professional nurses around." (Senior Manager)

Accountability was said to be at the forefront of the thinking of all professionals interviewed. The need to document and accurately communicate messages was raised by many practitioners but often this was equated with 'covering your back', rather than with 'meeting public expectation'. A senior nurse however linked accountability quite firmly with the feelings of professional vulnerability:

> "There's the anti professionalism that's sort of emerged from the Thatcher position about breaking down the elitist nature of professions which has led to professions defining themselves ... and now somebody from the outside is saying let's just have a look at what's going on here; lets just have another quality check, I think there's possibly public awareness of patients' rights, or more where they can complain, that they have a legal right to care that perhaps they are not getting." (Senior Nurse Manager)

Other respondents took the view that as professionals, nurses should not feel threatened but, conversely, should welcome professional scrutiny and analysis. It was argued that this was an appropriate time, both from an economic and moral perspective, to initiate a review. One respondent proposed an open debate around the issues of professional activity and delegation:

> "I feel almost a Royal Commission coming on in health sector education ... it feels as though we need the grand look, the grand strategy. All professionals are in conspiracy against the laity. I'm highly ambivalent - certainly the public shouldn't rely on politicians to look for their long term interest; politicians are only interested as far as the next election, but the professionals are there to actually protect an innocent public and that's actually in our statute." (Senior Education Manager)

> "There'll clearly be a scrutiny of what nurses can offload and can give to people that are less costly to train and employ and I think that's quite right, that should happen." (Senior Education Manager)

Clinical Supervision

According to three respondents the crucial issues of quality, standards, accountability, professional scrutiny and analysis should, in part, be addressed by systems of clinical supervision (DoH 1994d; Faugier & Butterworth 1994; Kohner 1994; UKCC 1995, Nicklin 1995). Clinical supervision is defined by Butterworth as "an exchange between practising professionals to enable the development of professional skills" (p 9) and according to the chief nursing officer at the Department of Health is "fundamental to safeguarding standards, the development of professional expertise and the delivery of quality care" (DoH 1994d p1). Subsequently the UKCC (1995) published its "Position statement on clinical supervision" in which it asserts that clinical supervision "will play an increasingly important part in ensuring safe and effective standards of clinical care" (p1). It is noteworthy that this political and professional imperative, that for two years has been the subject of sustained consultation, debate and publicity, should merit the considered comments of so few respondents. One respondent, captured the sentiments of others:

> "By disposition I'm optimistic ... intuitively clinical supervision is such a good idea and it should yield benefits for patients, the professions and purchasers... but there is a shadow side ... the recent history of the NHS challenges my rational instinct. I suspect for many, though not all, clinical supervision may be just another ritual, another kitemark, another box to tick, just something else to feel guilty about." (Senior Education Manager)

One of the colleges in the study was, at the time of the interviews, preparing to undertake a piece of action research in collaboration with an NHS trust in the area of clinical supervision.

3.0 ***Key Issues***

3.1 The sustained pace of change within the health service points to the need to prepare students from the commencement of their training to manage personal change, and examine personal resistance to change.

3.2 It was evident that managing the transfer of the focus of care from hospital to community, and addressing the corresponding development needs of community nurses was not necessarily facilitated by the separate responsibilities and perspectives of acute and community trusts.

3.3 The rising influence of GPs in determining the work of community nursing staff was noted.

3.4 As the largest group of professionals within the NHS, the deployment of nurses was viewed as being of key concern to commissioners and trust boards alike. It was generally agreed that increased flexibility of role within the UKCC's

Scope of Professional Practice, was a pre-requisite for the future delivery of health care and that educators had a key role to play in these developments.

Development of Community Centred Services

Within the field of mental health the shift in the delivery of care from hospital to community has a ten year history. In all of the trusts the inpatient services previously provided within large psychiatric hospitals had been gradually and substantially reduced. For one of the trusts in the study, this had entailed the complete closure of two such institutions within the last four years. For another, the inpatient population of one red brick complex had reduced from five hundred to two hundred, and would continue to decrease until there were twenty beds left on site. As the process of de-commissioning the large institutions (and realising the revenue savings and capital) continued it was evident that managers at all levels had a clearer picture of the future than did their counterparts in acute services. Yet two things remained to be resolved. The first issue was that of rising unit costs in the interim period as inpatient numbers reduced whilst the fixed costs of running the (mainly ageing) buildings remained high. The Audit Commission's review of mental health services for adults, "Finding a Place" recorded that 66% of expenditure on mental health services was still attributable to inpatient care (Audit Commission 1994a p 7) The second was less tangible - despite the maturity of the process, it was implied that a fundamental perceptual shift had to take place. A senior manager commented:

> "At the moment it feels, certainly within (name), that we are a hospital based service which has community outreach available. Whereas I think most people looking towards the future see mental health as a community based service which has hospital beds as a back-up." (Senior Manager)

Thus within a relatively short space of time, it was envisaged that the shift would be complete; with mental health services being firmly based in the community, using the hospital service where necessary as a back up for clients too disturbed to contain within the limited staffing complement of a small community resource centre (DoH 1994a). The view here presented is consistent with national strategic direction (Audit Commission 1994a).

A view of the spectrum of mental health care and treatment provision was laid out by the managers interviewed. At one end of the continuum lies the view of "normalised" services provided from the GP's surgery in the same way as, for example, health visiting services. A middle manager responsible for CPN services remarked:

> "We are looking at mental health liaison and to primary health care teams. We work closely with other community based health care professions and the links with health visitors for example are far better than the links with GPs. So really moving away from having compartmentalised mental health services on large sites into integrating them into the run-of-the-mill community services."
> (Middle Manager)

Managers were divided as to the role of the CPN in this aspect of care provision. NHS trust managers echoed the fear expressed nationally that involvement of CPNs with those clients presenting with less severe mental health problems makes them less available to those with severe and enduring mental illness. This concern was expressed by the recently published report of the Clinical Standards Advisory Group (1995):

> "Performance in this area (primary care liaison) was unsatisfactory ... Clinicians of all health professions in several districts were concerned about the effects that GP fundholding was beginning to have on practice. Worries were repeatedly expressed (particularly in the district with the highest proportion of fundholding practices) about a possible drift from the priority given to the severely mentally ill."
>
> (Clinical Standards Advisory Group, 1995 p 27)

Clear statements on the priorities for the specialist mental health service, were made by the Audit Commission (1994a), and by the Review Of Mental Health Services, "Working in Partnership" (DoH 1994a).

> "Community Teams should focus on people with severe mental illness as a first priority ... Those with less serious mental illness also need effective care but this need not necessarily involve specialist teams."
>
> (Audit Commission, 1994a p 35)

> "We recommend that the essential focus of the work of mental health nurses lies in working with people with serious and enduring mental health in secondary and tertiary care, regardless of setting." (DoH 1994a p16)

The former report had previously pointed out the current reality, and its implications:

> "Nationally CPNs have shifted their working patterns away from those with severe problems and a quarter of all CPNs do not have a single person with schizophrenia on their caseload. This implies that large numbers of people with schizophrenia ... do not receive adequate community support."
>
> (Audit Commission, 1994a, p33)

In addition, and crucially for this study, this finding has serious implications for the type of experience received by students on placement with CPNs. Educators must take case mix into account in assessing the validity of available experience.

That this issue represents a conflict of interest and expectations is evident from the response of a chief nurse adviser to a family health service authority. When interviewed (in December 1994) he expressed the frustration then being felt by GPs:

> "GPs would, in the main, much rather see the skills of the CPN practice focused so the CPN needs to become much more primary care orientated than delivering secondary care in the community." (Senior Manager)

The issue also has important implications for the work and training needs of non-specialist nurses in the community, such as health visitors, district nurses and practice nurses as was pointed out by Butterworth (DoH 1994a p27). The report offers a framework for collaborative working.

In line with another recommendation of the Audit Commission (1994a), respondents acknowledged that the range of crisis intervention services had to be developed beyond the "consultant on call". To support both professionals and lay carers, one trust had set up "fast response teams" which could intervene when individual social and health care strategies failed, or when the client suffered an acute exacerbation of symptomatology:

> "If that comes together we will have a wider range of crisis facilities which would include teams which would visit people at home, different sorts of residential facilities apart from hospitals which may just be safe houses, because it is not always a medical type environment that you need, it maybe just removal from their domestic situation." (Senior Manager)

There was a recognition that promoting a normal life for clients with enduring mental illness in the community had to be balanced against society's demands that any threat to the client or to others should be , if not eliminated, then minimised and that nurses had a key role to play in relation to this.

Towards the centre of the spectrum of care for mental health users lie the community units and resource centres. Physically remote from the old hospital sites, these centres would, respondents hoped, render mental health services both more accessible and acceptable to clients and prospective clients. Where they exist, these units provide a base for a variety of clinical staff - consultant psychiatrists, psychologists, CPNs, occupational therapists and, in some places, social workers. They also provide small numbers of inpatient beds staffed by RMNs and support staff. Day hospital facilities are an integral part of the provision, and specific therapeutic services are offered such as anger management, desensitisation programmes, stress management and the like. The manager of one such unit described the target client group:

> "It's not envisaged within this operation that it would take the most disturbed persons, or persons who were not known to the service and had a potential towards violence. Because of its community setting that wouldn't be appropriate." (Senior Manager)

Whilst these units retain separate community and in-patient service staff, there is greater confidence in the ability to offer a seamless service. The same manager explained:

> "If a CPN has got somebody they feel is becoming poorly and may need a few days inpatient care to look at the medication or whatever, then that is discussed in advance and the key worker will be identified within the in-patient side, even prior to admission. Attendance at the day hospital is built into their programme as an in-patient which then gets continued on when they return to the community." (Senior Manager)

Ultimately, the view was of the development of outreach services, with key workers involved in caring for people in the residential facility then actively helping clients re-

settle into the community. The manager of one such resource centre gave an example:

> "I mean, for example, one chap was homeless and there was involvement of finding him somewhere to live, and the key worker was involved ... with negotiations. Social services, obviously found an appropriate residence for this chap, they actually went with him, looked around it with him, gave him support and then when he was actually was discharged he went with him and he sort of kept in contact with him ... you know gradually tailoring it off, so that there isn't just an absolute cut-off point ... you know you're better, away you go." (Centre Manager)

Respondents stated the view that the closer link with the individual client's home circumstances offered by this model of care increased the likelihood of accurate diagnosis and appropriate treatment. A ward manager cited a recent example of a client who presented as obsessional and who was found, when visited at home, not to demonstrate behaviour consistent with the diagnosis. It was recognised that the interface between these outreach activities and the CPN service was becoming blurred. The manager of a locality based mental health facility explained:

> "I think in the resource centre we actually go out if it's needed. If they're ill we'll go out and see them and things like that, if it's one offs or two offs and maybe if it's just a supportive visit. It's keeping your eye to make sure that they are remaining stable ... then an outreach worker would do that, because they've been involved with them along the line; but acute psychiatric assessments or crisis, then the CPN's would follow those up."
>
> (Centre Manager)

Respondents appeared to favour the independent staffing of community services and in-patient services on logistical grounds. It was believed that integrating the staff would impact negatively on community services because of the tendency of wards to suck in resources. As indicated above, this tendency would be likely to increase as the in-patient population dwindled to embrace only the acutely ill.

All respondents expressed the opinion that within the following two years the services which would be provided from the old psychiatric hospital site would be confined to a few specific areas such as the care of mentally disordered offenders and those exhibiting challenging behaviour, and the assessment of the elderly mentally ill and those with severe mental illness. It was suggested that as more and more services are placed out into the community, those provided within hospital would coalesce to form a distinct speciality:

> "... for patients who are left behind in hospital, whoever they may be ' thi..k by the very nature that they're all left behind, they'll have some common ground that will allow people to develop a specialist service." (Senior Manager)

Thus it was perceived that a new specialism might arise within the old hospitals.

Despite the unanimous acceptance of the community care model in the mental health arena, there were still acknowledged problems in establishing good communication processes to underpin the relationship between hospital and community. It was

recognised by both hospital and community services managers that community nurses were frequently not involved in discharge planning, either because they were not invited to the planning meeting, or because they had prior commitments at the time of the meeting. This problem reached acute proportions in the case of a medium secure facility with a national catchment area:

> "We feel the need to follow up the people - particularly the sort of people we are dealing with here that are at risk to themselves or to other people. We have awful problems here with making sure that '117 meetings' which is the part of the Mental Health Act that specifically refers to planning after care - that they happen, that they're effective and that they are actually work in the patients best interest. Often they're lip service or they're not attended by people who really matter. So we feel that people we invest a lot of time, the people here, we're chucking them basically into the deep end to see if they sink or swim without adequate aftercare." (Senior Manager)

The introduction of the care programme approach was raised by only one senior manager respondent in relation to staff training, and is discussed within chapter 7. It would however be remiss of us not to acknowledge here that the requirements of this initiative must feature in pre-registration curricula. According to recent Department of Health Guidelines (DoH 1994g) the key features are:

> "
> - a systematic assessment of health and social care needs (including accommodation);
> - a care plan agreed between relevant professional staff, the patient and his or her carers;
> - the allocation of a key worker whose job (with multidisciplinary managerial and professional support) is:
>
> to keep in close contact with the patient;
> to monitor that the agreed programme of care is delivered; and
> to take immediate action if it is not;
>
> - a regular review of the patient's progress and of his or her health and social care needs." (para 9)

The Current Role and Competencies of the Nurse

Not all that nurses do is exclusive to that profession. Most respondents recognised that there was considerable overlap in the work of the nurse with that of other professionals both within and outwith the Health Service. Although the issue of multi disciplinary team working is explored in chapter 7, it will become evident that in discussing the role of the nurse many respondents offered clarification in terms of a comparison with members of other professions. The extent of the overlap between nurses and others in the mental health arena occasioned some nervousness from managers who were themselves RMNs as there was a belief that this lack of clear definition of the role of the nurse made the profession vulnerable in the medium to long term. This flexibility of role could, however, be viewed as a positive strength. Because of their traditional 24 hour presence in care settings, and the consequent need to "cover" for other professionals in their absence, nurses had both a diverse range of skills and an understanding of the role of other professionals that was

unmatched within the multidisciplinary care team. A senior manager for mental health services expressed the following view:

> "Either we move towards some sort of generic training and generic working as one option or we recognise that nurses because of the position in the organisation, are traditionally taking on this wider role of co-ordinating the care. Not necessarily because nurses are more talented than any other discipline but because they tend to be present more of the time. I think within mental health, whether it is moving towards the same model that social workers have where they have care managers putting together packages of care." (Senior Manager, Mental Health)

Not everyone however was comfortable with the ill defined role of the nurse. An exhortation to clarify the issue was voiced by a senior manager:

> "I think nursing has got to define its role clearly and what contribution it's going to make to the team, other than picking up the debris of what everyone else doesn't want to do. Because they are highly skilled, they are much more experience than many of the other professions in dealing with the patients because of the training they have come through and the intense amount of time they have had to spend with patients during the training time. They need to clearly identify what are they going to be doing." (Senior Manager)

In presenting the findings of the study we first present the aspects of role which were explicitly shared with other professionals, then move on to what was held to be the specific, unique contribution of the nurse.

Health and Social Needs Assessment

The majority of participants in mental health settings stressed the importance of the nurses role in assessing the health care needs of clients and their families or other social support groups. This involves a complex array of skills involving listening to words spoken, interpreting their meaning in the light of other cues and validating the conclusions drawn by reflecting the conclusions back to the client for comment. It was recognised that in the mental health arena this act of assessment often requires a suppression of 'normal' reactions to an individual whose behaviour may in some aspects fall outside the range of social acceptability. A manager responsible for the mental health branch in one of the colleges stated:

> "It's quite an art listening to someone who's depressed. It's quite an art and a skill staying interested in someone who's being aggressive; it's quite difficult to listen to someone who's in a high state of anxiety or agitation; it might be quite difficult for people to understand what it is someone with schizophrenia who's hearing voices is actually experiencing; and I think the skill of the psychiatric nurse is that they can look at all those different types of symptoms that people present with; they don't shy away from them and say, 'Oh this is difficult' ... they try to understand what the patient is feeling as well as what the patient is saying." (Educator)

Most respondents recognised that other professionals also assessed clients and their families and that many of them would describe their assessment as holistic. It was however postulated that the nurse's knowledge of psychiatric aetiology and pathology, combined with their awareness of the social context in which clients operate, and the

comparatively lengthy time they spend with clients in a variety of settings; all equip the nurse to produce the most broadly based assessment of all the professions. A mental health senior teacher:

> "If it's planned correctly in an intensive way, you can gain data by watching how a patient drinks a cup of tea ... a ward sister I knew trod in a patch of urine and from the stickiness of the urine decided to test it and determined there was sugar in it ... It wasn't her job to diagnose diabetes, but it was her job to know something that was significant." (Educator)

One of the key differences between nursing in the community and nursing in institutions is that this time for interaction and observation is significantly reduced:

> "We must all have known examples of people whose mood was drastically different in the morning to what it was in the afternoon, therefore a community psychiatric nurse's assessment of the patient's mood may be down to the time they choose to visit - that has to be a reduction in the quality of data."
> (Manager, Mental Health Resource Unit)

Nevertheless, the skills of assessment were held to be the same - what differed in hospital and in community was the pattern of client contact and the opportunity for assessment in the real world context. The perspective of nurse managers interviewed was that the nursing assessment was more holistic than that of other professionals. Whether doctors, social workers and occupational therapists (the most frequently mentioned members of the multidisciplinary team) would concur is a moot point.

> "(Nurses) can give a more overall view of a person's needs, rather than other members of the team who may possibly look at more specific areas in which they are trained." (Middle Manager)

In defence of the "holism" claim, respondents put forward the argument that nurses had a greater understanding of mental health pathology than either social workers or OTs. They were also able to interpret behaviour in the light of this known pathology. An inpatient ward manager told the following story by way of illustration:

> "Basically this person had been referred for as I recall: needs to be able to socialise, needs to be able to cook on a one to one basis, needs to be able to develop skills to enable him to live by himself. You know it was presented back that yes, this person was saying that he couldn't cook and he sort of lived on sandwiches, and no he doesn't get washed when he gets up on a morning, and presented sort of a bit of unkempt, etc ... but then he said ... something about "and I don't eat with other people because they may be putting stuff in my tea" or something like that ... He was really very deluded. You know it had been missed, so I think it's the pathology, but it's also I think having the skills to explore areas that that need to be explored, to be able to get a true picture of the mental health state of that person." (Ward Manager)

According to this argument nurses were, theoretically at least, in a position to take into account not only psychopathology but also physical factors such as anaemia, which might impinge on mood state. In carrying out a health needs assessment, nurses could, alone amongst the non-medical multidisciplinary team, also isolate iatrogenic symptomatology. Balancing this medical perspective was the social perspective that nurses brought to assessment and treatment. Nurses, from their background as round

the clock of care, had personal insights into the difficulties experienced by clients' families, friends and significant others. They were said to be highly able, by virtue of their training and experience, to assess social functioning and the degree of social support offered by the community:

> "Even if somebody's doing a full week of nine to five occupational therapy, the OT's view is going to be of the patient within therapy, not of the effect of therapy generalised to their behaviour with other people, and of the rest of the ward, or difficult circumstances with the family. If they have regular sessions with the psychologist, the only thing they're picking up is what is happening within those sessions, which might be very important, but you don't have the behaviour observations of what's happening for the other twenty four hours of the day." (Middle Manager)

The perceived developments in this aspect of the role of the nurse lay in broadening the scope of the data which would be collected. In response to a specific follow-up question as to the effect of the reduction in junior hospital doctors' hours on the role of psychiatric nurses, one senior manager suggested that there was potential in the current climate for nurses to be less fearful of overstepping role boundaries. If when visiting a client the nurse had a suspicion that reported lethargy and fatigue might be related to a poor nutritional state, they could actually take steps to determine this by taking a sample of blood there and then.

The area of risk assessment and management was mentioned by managers in relation to developing competencies. In the wake of media interest in homicidal and suicidal events involving psychiatric patients in the community, there was considerable interest in developing skills related to increasing the predictive validity of such assessments:

> "I suppose the other element is about risk assessment ... The first choice won't always be hospitals where there is plenty of back-up, plenty of staff, but will be in the community. And it will be making value judgements on whether that package of care can support that person. It seems we have bottomed out, if you like, the compassion within the community for mental illness and now people are demanding compassion for people who are mentally ill but combined with safety for the general public." (Manager)

This was echoed by a manager in another part of the country:

> "I think a lot of it is going to depend on how the Department of Health responds to the pressure of risk incidents of patients who have a mental illness. I have a great feel for reactive behaviour - supervision registers and supervisory community discharge arrangements being part of the package."
>
> (Manager)

Whilst it can be argued that psychiatric nurses have always assessed risk, for a number of reasons, practitioners are increasingly required to adopt a systematic approach to the assessment and management of risks to and from clients. It is axiomatic that the underpinning knowledge and skills must be addressed in both pre- and post-registration education. Nowhere is this felt to be more urgent than in the field of mental health.

Whereas in the past the nurse has contributed to the decision to discharge, the responsibility has always lain elsewhere. Similarly, in respect of clients in the community, the nurse has been in the position of relaying concerns to others, but the power of compulsory admission under the Mental Health Act has resided with medical staff and social workers. Nurses, it is claimed, have been protected from the consequences of their actions.

Supervised discharge arrangements, which are a key feature of the Mental Health (Patients in the Community) Bill currently going through parliament are designed to identify:

> "... all individuals who are under the care of a provider unit known to be at significant risk or potentially at significant risk of committing serious violence or suicide or of serious self neglect as a result of severe and enduring mental illness." (NHSME HSG (94)5, Annex A, p2)

These measures have a number of key implications for nursing. For example, the responsibility of the key worker will be significantly increased as they may be required to convey any patient who has discontinued treatment to a centre where that treatment can be re-established. It is unlikely that this step would be taken by a nurse unless the non-compliance was perceived to put the client, or others at immediate risk and in any case, this extension to the role of the nurse is currently the subject of intense debate within the profession.

The Role of the Nurse as Care Manager

The distinctive hallmark of nursing as presented in this study is its tradition of providing 24 hour care. This picture of the nurse as the person responsible for providing for all the needs of the client was still strong, despite the move towards, and firm commitment to, community care where the model of 24 hour presence (as opposed to 24 hour responsibility) was inappropriate. This was rather unengagingly expressed by one ward manager:

> "The people who are on the ward all the time are the nurses, and they see themselves as generally, as a lump of people on the ward, we populate the ward; we are the constant presence if you like, and therefore we tend to often be sort of speaking for other colleagues, as well as ourselves."
>
> (Ward Manager)

The focus of this role of the nurse is care rather than cure, of maintenance rather than change. In a hospital setting, the nurse is constantly present in patient areas. The notion of nurses being alongside service users, empathising with their changing moods and reactions is a strong thread throughout the interview transcripts. The unspectacular nature of this aspect of the role was discussed by a middle manager in a community and mental health trust who accepted, even celebrated, the fact that mental health nursing frequently appears somewhat mundane:

"I think maybe we need to get away from where there's an answer for everything. Perhaps a relationship that the nurse can build with the patient can help them understand the situation and help them come to terms with the situation. Perhaps that's more important than finding all the answers for someone." (Middle Manager)

The emphasis on the importance of getting alongside the client in such a way as to support him through both illness and therapy was echoed by a middle manager in the independent sector:

"Nursing is about people working with the client really, alongside them, doing things together. You know nurses can carry out treatments - anger management or whatever - but the trick is to actually be working along beside the person. It's actually getting them to that stage where they actually accept their anger management treatment - it's helping them to access the services available...and to realise when something is working ... and it's about giving people regular feedback what's happening, particularly the more disturbed people." (Middle Manager)

That the nurse has an acknowledged and unrivalled expertise in relation to the care of the most disturbed clients was a claim made by several respondents: . Another respondent addressed the unasked question as to why nurses were the undisputed key workers in hospital, yet others could pick up the role when the client returned to the community:

"Yes, while they're in hospital the nurse is the designated key worker ... because when patient a comes into hospital, they're more acutely ill, so their needs become more geared towards what a nurse can deal with."

This assumption that nurses are the professionals of choice to deal with the most disturbed clients could be taken as a tribute to a high skill level required to care for clients demonstrating the greatest pathology. One senior manager in the same organisation echoed the sentiment and attributed this skill of the nurse to the client focused education which distinguishes nurses from other professionals:

"They haven't got the level of training which is actually hands-on people orientated training which gives you, by the time you've come through your three years, X number of hours of actual sitting with people like this. And that to a certain extent is the only way that you can learn how to communicate and deal with people, especially people who are extremely poorly or who are extremely distressed over something. That is born out by the fact that patients, when they do tend to feel at their worst, who they approach and it's nine times out of ten the nurse rather than anybody else." (Senior Manager)

Thus it was implicitly argued that the role of the nurse in hospital settings in the future was assured. As has been previously highlighted, service users admitted to hospital will increasingly be those displaying anti-social, or indeed offending (in the criminal justice sense) behaviour. Again and again managers emphasised that the care of mentally disordered offenders was a high priority for the service in the future. This reflects the concerns expressed in the Reed Report (DoH/HO 1992).

The important place of forensic psychiatry in the future of mental health services was repeatedly stressed by senior and middle managers. This was further supported by the mental health expert panel who reviewed the competency statements contained within the survey instrument. It is interesting to note that this area of work was not mentioned by practitioners in any of the mental health focus groups.

In the light of this, the nature of hospital care would, it was argued, almost inevitably change. It was recognised that the concentration of acutely ill clients in institutional settings would change the ward culture and the resulting skills and support needs of staff.

> "I think the pace of work will increase, dealing with crises will probably increase, again if you only have two or three acutely ill people you could effectively isolate them from the rest of the patients. In circumstances where the level of disturbance rose so that you had a significant number of acutely ill patients, that has an effect on the rest of the population, in that anxiety is almost infectious. Humans are built to detect alarm signals and therefore the level of disturbance tends to increase overall. Disturbance creates disturbance." (Education Manager)

This same respondent, an education manager, likened the increasing managerial stresses on staff to moving from being air traffic controller at a small country aerodrome to taking responsibility at London, Heathrow:

> "You've got more data flying at you faster, and you have to make more judgements. The more you put people in the situation of having to make judgements which may have serious consequences more rapidly more frequently, the more likelihood of errors occurring." (Education Manager)

Nursing in Community Settings

It was argued by some respondents that the traditional residential "twenty-four hour" care responsibility of nurses uniquely fits them for contemporary models of care management in the community. It was suggested that nurses can take responsibility for a client over a twenty four hour period with some informed view of how all the activities of normal living might be affected by the client's mood state. It is this tradition of nursing, argue respondents, which marks nurses out as being particularly fitted for being the key worker within a care programme approach. Within the community, however, this concern for all aspects of the client's life finds expression in the construction of a programme of care which involves many other professionals.

In order to become successful negotiators rather than direct deliverers of care, nurses increasingly require skills of negotiation and assertiveness in ensuring that clients have access to required services. There was a belief amongst managers that this was an area in which nurses required further development. Nurses, even community psychiatric nurses, do not always regard themselves as the gatekeepers they are in reality. It was acknowledged that the unique contribution of the nurse is as a cohesive

and lubricating presence, "like the glue holding the whole thing together," as one manager put it, or the oil which promotes a smoothly running care machine. As with adult nursing, the psychiatric nurse is also additionally regarded as the professional who fills in the gaps and thus, in addition to glue and oil, can be characterised as polyfilla!

There was a divergence of opinion as to whether the fundamental role and competencies of psychiatric nurses differed in community as opposed to hospital settings:

> "I think the skills are the same if we are talking just about secondary specialist services. The skills are the same. The fact that the contact is in hospital or community I don't think is relevant. Even now we deal with acute episodes in the community, depending on the individual, as well as in hospital."
> (Senior Manager, Mental Health)

This senior manager went on to comment on the current educational provision for CPNs:

> "What I can't reconcile in my own mind is why CPNs, as they are nowadays, require an extra twelve months training, and certainly any outcome of training in the future must equip someone to work in all the different environments and not just the hospital." (Senior Manager, Mental Health)

This view is strongly supported by Butterworth (DoH 1994a) who recommends that:

> "... the title 'mental health nurse' be used both for nurses who work in the community and for those who work in hospital & day services."
> (DoH 1994a, p20)

Nevertheless, respondents indicated that there are differences in approach in the two settings. Within the community, relationships with clients become more intensive. It was argued that it is possible, perfectly legitimately, to spend a hospital shift talking to other members of staff, writing records administering medications, answering telephones and organising admissions and discharges. The resultant contact with any one client can be a pattern of brief episodes. Life is different for the nurse who visits clients at home and who is likely to be afforded the opportunity of an uninterrupted, relatively lengthy period with one client:

> "I think if a qualified psychiatric nurse has already got the skills to work in the community, she perhaps needs to develop them because they're working in a different setting, working a lot on a one to one basis ...they probably would need to develop their communications skills even more." (Ward Manager)

One of the best comparative descriptions of inpatient and home-based nursing was given by the manager of a resource centre of the type described above. In this setting, nurses staffing the small in-patient facility were doing outreach work, following service users into their own homes. Resident clients would typically go home for a few days, and be visited there by a member of the in-patient staff. The quotation pulls together into one paragraph most of what was said by a succession of managers and practitioners on the subject:

"I think observational skills are very high on the list, because they actually support awareness as well being aware of their own prejudices, and their own feelings etc, because they are starting to follow the patients to their own homes ... The difference between nursing somebody on the ward an nursing somebody in the community can be quite scary really, because in the ward you've got the institution there around you. When you're in somebody's home, a) you're a guest in their home, and you've got to change your approach, and b) if you decide on something or take a course of action, then you are totally responsible for that, so I think it's maybe the confidence of being sure what's going on and to be able to do an in-depth assessment for what is needed and also to make sure that you negotiate all along the line with the patient themselves. You know does the patient really want this? Is it right that this should be offered and involving the career as well, so it's multi-factorial really, isn't it, it's looking at all the factors that surround there and setting up all the mechanisms that are necessary." (Manager, Resource Centre)

The enhancement of observational skills relates to an earlier recognition that in community settings the nurse loses one of his or her greatest advantages - that of twenty-four hour presence. In visiting clients at home inferences have to be made about life during the part of the day or week or month that the nurse is not seeing. Thus direct observation of eating and hygiene habits and of responses to frustrated demands, has to be replaced by other, more subtle means of making these assessments such as the presence or absence of food in the house, references to shopping trips, evidence of neglect of personal or domestic hygiene etc. Then too the quotation highlights the need for nurses to examine their own prejudices. Hospitals are, by and large, run according to the values and standards of their staff; homes, and relationships within those homes are organised in accordance with the standards and values of the client.

The above quote also describes the "scariness" of community working. There was a recurrent theme in discussions about community based practice which, highlights the need for personal, rather than skills, development in the move to community care. Nurses would have to deal with the anxieties inherent in working alone, without recourse to an immediate second opinion or a back-up team:

"It's sort of a safe environment for the nurse as well to work in a hospital, so they would need to look at their own coping mechanisms, and re-evaluate those and develop their own."

This entailed increasing confidence in clinical decision making and risk management as stated above. In any care plan the professional's aspiration to promote for the client a 'normal' environment must be balanced against society's demand that there is protection from those whose mental condition might lead them to commit violent acts.

This issue was addressed by mental health nurses in the focus groups. They spoke of the anxiety invoked by risk assessment in a community setting:

"(risk assessment) It raises professional accountability for you, when people come in for a day and they are going home at 4.30 or 4 o'clock you have to sometimes make a decision whether you should let that person go home or not." (Mental Health Nurse)

"In terms of risk management though we need to be very clear as to what we are doing because of litigation and the other things that are coming up more and more frequently." (Mental Health Nurse)

Within the study respondents indicated the importance of the move by the English National Board to commission a research study into the effectiveness of educational preparation for risk assessment and management.

Other areas of personal development highlighted included the need to improve negotiation skills and to become more assertive within the multidisciplinary team in order to discharge the responsibilities of a care manager. Negotiation skills were required too, in their dealings with clients. Treatment can only be given with the consent of the client whatever the setting, but within the bounds of an institution there is an implicit consent (or legal permission) in the status of the in-patient which is absent if the treatment is to be given in the community.

The Therapeutic Role of the Nurse

The overwhelming and consistent message from managers was that the mental health nursing service must become more explicitly therapeutic, combining this more pro-active role with that of care (hospital) and co-ordination (community). One senior manager responsible for inpatient services stated unequivocally:

"I am a strong believer that ... the primary role of the psychiatric nurse is to act as primary care providers, in relation to treatment programmes, not just from the custodial point of view, just a sort of a living skills point of view. I think they're always very good at making sure the patient's fed, watered and they look after themselves etc ... but I think they can be very poor at doing programmes of care, that deal with their particular problems, whether that be on a one to one basis using a one to one psychiatric nursing skills for example counselling or anxiety management, and also in relation to group skills, and I think the nursing staff really have to , to consider what their role is, my view is very clear they have to be seen as primary care providers ... they have to be seen as the key worker, in relation to providing care, not actually co-ordinating care, but actually providing care in terms of treatment plans."

(Senior Manager)

A senior manager responsible for forensic psychiatry services expressed his view:

"Too many community nurses see their role as making sure things are running smoothly, patients getting their meals on wheels ,they're getting their depot injections, they're attending the out-patients appointments without really looking at the contribution that they can make to the therapeutic care."

(Senior Manager, Forensic Psychiatry)

It was suggested by one senior manager that the role of nurses in the administration of drugs, which was mentioned by many as one of the really *unique* skills of the nurse should be developed into the area of nurse prescribing, particularly in relation to those drugs which counteract the side effects of prescribed medication.

It was noted that whilst many nurses are involved in counselling, and in the delivery of programmes of anger management and stress management, this was an area which has been open to take-over by other professions. It is interesting to note that the words used to describe those areas appropriated by other professions were consistently those stressing the passivity of nurses, rather than the aggressiveness of others. Such areas of work were "given away" rather than "stolen." It was however recognised that some other professionals had some built in advantages. By reason of not being required to provide twenty-four hour coverage staffing of psychology and OT departments was more consistent than that of ward areas. Therefore a stress management group could run at 3 pm every Wednesday afternoon secure in the knowledge that staff could diary this time.

Another aspect of the move to an increasingly therapeutic role was that nurses should become better able to articulate the nature and rationale for interventions:

> "As you go into a ward or into a day hospital and say 'What have you done this morning?' They would say 'playing scrabble, we watched the television', they don't say 'well we have tested the social interactive skills of the patient by playing a game, using that as a vehicle'. And because they have fallen into that sometimes some nurses are not always that clear about what skills they have to offer." (Middle Manager)

The development of the role of the care manager, care co-ordinator or key worker lends breadth to the planning role of the nurse.

The Educating Role of the Nurse

Given the known identity of the commissioners of the study, and the educational focus of the title, it is unsurprising that much of the discussion around the educational role of the nurse centred around the supervision of student nurses. The points made by many respondents were summarised by a ward manager of a mental health unit:

> "They need to be able to teach people, teach others so that, they can work to their level They need to be a role model to others, and you know they just need to make sure that they are responsible to carry out that care, responsible for themselves and responsible for others. Responsible for themselves in that they make sure they're updated so that they are able to carry out the care, responsible for others so that they know other people are carrying out the care that they have prescribed." (Ward Manager)

However, there is a recognition that the caring and therapeutic roles of the nurse also have an educative function. Anger management is therapy, but the outcome of that therapy is that the client learns more appropriate strategies for dealing with anger than those hitherto employed.

> "They're making them, making individuals more aware of themselves, of their health, their mental health, their general well-being ... assisting them, where possible to become well, in an education role, with all sorts of training. They seem to be taking on more sort of group work activities, which maybe in the past may have been done by other group professionals" (Middle Manager)

One senior manager responsible for forensic services described the public education role of the nurse

> "Of course there's a big educational component, we're forever being called on to go and do, go and share this workshop or can you come and do a talk on this that and the other." (Senior Manger, Forensic Services)

Whilst the legitimacy of this activity was not questioned, there was believed to be some degree of role conflict as these invitations multiplied and were responded to at the expense of time spent with clients. Inevitably it was the best and most articulate staff who were chosen for this public education role.

The Role of the Nurse as Manager

The term "management" was used in two distinct senses within the transcripts. Firstly as manager of care - the person responsible for the planning implementation and evaluation of the care package. However, whilst there were many references to care management, anger management, group management and the like, interestingly, amongst the mental health managers interviewed, there was only fleeting reference to management in the sense of ward administration and leadership, and the effective use of financial and human resources, and this in relation to the lack of these skills amongst newly qualified staff. Managers were highly critical of the ability of newly qualified nurses to deploy staff and other resources. This is explored in Chapter 8 in the discussion of educational issues.

The Role of the Nurse as Advocate

The skills necessary for the nurse to perform the duties of advocate have developed from the concept of nurse as front line protector and provider:

> "I think perhaps of any of the other professions nurses continue to be the patient's champion. I think nurses are far more involved with patients than other disciplines. I think they dedicate more time to individual patients than perhaps other professions ... I think the public still perceive nurses as key players. They are very much in the front line." (Nurse Manager)

Within the focus groups the concept was further explored. Whilst there was a recognition of the role of the nurse as advocate, overshadowing this was the awareness of potential conflict between the duty to the client and the knowledge of resource constraints. This was particularly an issue for mental health nurses who are increasingly working as care managers within community settings:

> "I think a role of the nurse is the advocate because especially in mental health they are not always able to speak out for themselves and it is falling more and more to the nurse." (Mental Health Nurse)

There are signs however that this will become the next area of specialisation to be separated out:

> "So there is an advocacy service being developed independent of us but we are supporting that development, and that will be to give input to patients.

> They will have two advocacy workers. I have some ideas as to how I want that service to develop, not from my own Machiavellian ends but I think if it is going to a meaningful service then it has got to be in there with the patient when the care plan is being discussed for those people who don't feel comfortable in a multi-disciplinary team setting."
>
> (Senior Manager, Mental Health)

Certainly, within the focus groups there was recognition of the inherent conflict between being a corporate professional and being a patient advocate:

> "If we are considering mental illness for the future if we have clashes of obligation to the patient and to the organisation and I feel that at this point in time that a lot of patients who are benefiting from advocates - there is a huge gap between the approach from the advocate and the professionals."
>
> (Educator)

Further evidence of this national trend is offered by an article on bi-lingual advocates in the Health Service Journal of November 1994 (Parsons and Rudat 1994). These workers combine translation services with client representation based on an understanding of the culture from which they come. The roles have been developed in direct response to the criticisms made within the Butterworth report regarding the experience of people from ethnic minority backgrounds in the mental health services.

Otherwise, respondents believed that, where an independent service was not available, nurses were well suited for the role by virtue of the nature of their relationship with patients as set out above. It must be recorded that this belief was somewhat at odds with their perception of nurses as advocates for their own profession.

4.0 *Key Issues*

4.1 Care management skills required by the care programme approach should be included in the pre-registration curriculum.

4.2 If the primary focus of the specialist mental health service does indeed lie with those with severe and enduring mental illness, this must be clear within pre-registration curricula, and be reflected in the balance of placements. In the light of this requirement, and the findings of the Audit Commission that one quarter of CPNs did not have a single person with schizophrenia on their case load, educators must audit available community experience to ensure that students receive an appropriate education.

4.3 Mental health nurses should celebrate their understanding of physical disequilibrium and iatrogenic symptomatology which lends them a truly holistic perspective and sets them apart from many other members of the multidisciplinary care team.

4.4 Manager respondents stressed the importance for the future of working with offenders. It is advised that in pre registration education, students should be given experience of working with mentally disturbed offenders - in forensic units, prisons & with the probation service.

4.5 Practitioners are increasingly required to adopt a systematic approach to the assessment and management of risks to and from clients. It is axiomatic that the underpinning knowledge and skills must be addressed in pre-registration education.

Managers in all acute trusts in the study discussed the issues involved in making the most efficient use of in-patient facilities. NHSE targets for day surgery, set at 50% of elective surgery at the start of the research study, are set to rise to 60% in the year following its completion(NHSE 1994e, 1995c). In addition to the expanding range and volume of these services, managers spoke of the introduction of a range of schemes to reduce the incidence of inappropriate admissions and to eliminate inefficiency during the patient's stay. Pre-assessment clinics were being introduced in all trusts albeit at different rates, and patients were increasingly being empowered to carry out some aspects of pre-operative preparation at home. According to Harley and Jayes (1995):

> "In the ten years from 1983 to 1993, the total number of general surgery finished consultant episodes, including day cases, increased by just under 10%." (p 27)

The drive to centre care in the patient's home whenever possible had had the effect that traditional boundaries between hospital and community care were gradually becoming less clear. Senior managers reported moves towards the introduction of hospital at home schemes, in which specialist practitioners would offer increasingly complex care in the home, and of the introduction of hotel services which would cater for those patients whose episode of care was viewed as complete, but who nevertheless would benefit from an overnight stay before embarking on the homeward journey. The implications of these changes for the professional and personal development of nurses are discussed below.

Day Surgery and Treatment

The degree of development of day surgery and treatment services varied in the trusts in the study. In one trust at the time of the interviews 7000 day patients were being treated annually, representing 50% of all planned surgery. The "lumps and bumps" traditionally dealt with in such units had given way to a range of surgery including vascular surgery, hernia repairs, cataracts, minor orthopaedic work, laporoscopic sterilisations and so on. In two of the trusts active consideration was being given to extending the length of the day to permit the removal of gall bladders on a day basis. Flexibility is the key to the nursing care on these units. The range of complex procedures requires that a broad range of knowledge and skills be acquired in order that appropriate care and accurate information is given to patients. Then too, the client group varies across all age groups, from children to the elderly. In addition, in areas in which these units are self-contained from a staffing point of view, flexibility is required between ward area and theatre. One trust and its associated college had

jointly developed one of the early ENB A21 (Day surgery and peri-operative care) courses to address the educational needs of staff. In another trust in the study, where services were growing rather more slowly, the ward sister had instigated her own training programme with due attention to the need to desensitise those who were anxious about working in the environment of an operating theatre:

> "How I worked it was, we circulated them in theatre first, to get them to learn about theatre and how it worked. Then we said to them, right, if you work in the back shop, clearing the instruments up, you'll get to know the instruments and how to handle them... and then we said, if you go into the scrub areas ... so you can see how the trolleys are set. The next stage was to scrub and actually set the trolleys and then we took them into theatre ... but with another nurse for guidance ... and now we find that they can actually run the theatre themselves." (Ward Sister)

The role of the nurse in day units is wide ranging. Nurses carry out the pre-assessment of patients using protocols developed in conjunction with anaesthetists. Additionally, as outlined above, they may participate in any aspect of patient care. Despite the large throughput it was emphasised by the ward sister interviewed above that the social and emotional needs of patients were paramount. She gave a recent example of a women admitted for a laparoscopic sterilisation who broke down immediately before discharge at the thought of taking her pain home to an abusive husband. This had required both sensitive listening and specific action.

It might be expected that the rapid increase in day surgery would have had a significant increase on the work of the primary health care team, and indeed one trust reported that research had revealed that 50% of patients discharged from the day unit had seen their GP during the five days following the procedure. However, there was limited information on the impact on community nursing services. A community services manager from a community trust explains:

> "They say there has been an increase in day surgery and that should have resulted in an increased workload in community nursing but unfortunately the information services that we have at the moment don't allow us to say, 'right, let's quantify that.' So we are a bit lacking there, really. We used to notice it when they used to get the waiting list initiatives...I think the general increase in day surgery has been a much more gradual thing which is difficult to quantify at the moment." (Manager, Community Services)

A recent study by Harley (1995) substantiates this impression, although there is an important caveat concerning the robustness of the data, based on Health Service indicators:

> "At national level, the number of referrals (initial contacts), the number of individual patients seen in the year (first contacts) and the total number of contacts in the year have not altered substantially since 1988." (p29)

Increasing Efficiency in the In-patient Period

Surgical pre-assessment had been introduced in all of the trusts in the study. In some areas, particularly that of day surgery, this was nurse led. In addition to the

assessment of the patient's fitness for surgery, information was given at these sessions about any pre-operative preparation required allowing patients to be admitted subsequently on the day planned for their surgery, appropriately starved and having met any additional pre-operative requirements:

> "We're wanting nurses to do pre-assessment clinics, taking over a lot more of the doctors roles." (Middle Manager)

> "It's happening on an ad hoc basis in every speciality. Some do it better than others." (Senior Manager)

The organisation of this was still under debate in the trusts:

> "The question is whether we have a centralised pre-admission area, or we have pre-admission located in every speciality." (Senior Manager)

Once patients were admitted, there was further potential for the nurse to be instrumental in increasing efficiencies and minimising delay. All of the trusts were engaged in developing protocols for care. Because these were agreed within the multidisciplinary team they had the effect of ensuring that a broad range of actions could be taken by the nurse in advance of patients being seen by the admitting doctor.

> "As well as speeding up the process of the patients through the hospital we're into deciding protocols of care ... We're also breaking down some of the barriers that actually delay patients. Looking at things like who can order x-rays. In the past patients often had to wait to see a doctor to have an x-ray ordered and really a trained nurse, a suitably trained nurse could actually prevent that delay." (Ward Manager)

A senior practitioner confirmed her manager's confidence in the ability of nurses to undertake such roles:

> "I think we tend to take on the responsibility if somebody is coming with a query myocardial infarction and the doctors just assume that the protocol is going to be adhered to without requesting blood of the patient, without requesting ECGs on the patient and we are automatically picking up responsibility for forms having gone to the appropriate department and we are trying to organise that as well ... We are actually working for the benefit of the patient, if they don't get the tests they require." (Senior Practitioner)

It is interesting to note that the nurse's rationale is firmly based in the benefit to the client rather than on the efficient use of time and resources. There is an explicit desire to offer patients better, streamlined services which properly value their time. However, such is the pace of change and technological development that one senior nurse manager described multi-disciplinary working groups producing protocols for care which were already out of date at the time of implementation.

Blurring the Boundaries - Acute Care in Community Settings

The speed of change has allegedly left gaps in the service attributed to the lack of time to develop a firm community nursing infrastructure. The burden, it was suggested by

one respondent, may fall to carers and relatives for whom support is insufficiently developed:

> "We're sending people out the day of their surgery or the day after and then we've linked with the community in deciding what care patients need immediately post op ... empowering families to care for their relatives in the community, that doesn't seem to be happening as quickly as people imagine." (Middle Manager)

A senior nurse manager told of the difficulties:

> "I think that in trying to reduce patient's stay but actually provide quality of care we've had to look at - if that patient goes home are there the facilities within the community and is the expertise there." (Senior Nurse Manager)

For those who have no carers or relatives to support them, the situation is bleaker.

Kendrick (1995) suggests that the dramatic rise in emergency admissions to hospital, a 5.2% increase in 1992-93, is attributable to the inability of community health and social services failure to cope with increasing demands.

> "All forms of social and primary care are under great pressure, so it is entirely plausible that increased demands for their services will be passed on, at least in part to the resource which never, or hardly ever, says no - emergency admission to hospital." (Kendrick, 1995, p 28)

In coping with this rise in admissions one trust in the study had developed a fast response team which visited referred clients in the home and offered support to prevent hospital admission should clinical criteria for admission not be met . This service was set up to counter the perceived tendency of GPs to refer elderly clients for admission to hospital when they can no longer cope at home. That this is not necessarily an accurate explanation of the rise in admissions is evidenced by Harrison et al (1995). The requirements of the nurse in this situation are to make an assessment of any community nursing or social services required and to provide nursing support for 48 hours whilst social services set up more permanent measures.

It was recognised that the changing focus from hospital to community care requires permeable boundaries between, and redefinitions of, primary, secondary and tertiary care. Early signs of such boundary changes are described by a nurse manager in medical services.

> "There'll be a bigger emphasis on out-patient work and we've already demonstrated that on the medical floor. We have a link now for the first time with out-patient and in-patient, so the nursing services now, (have) ... more continuity between the two. The staff themselves will become integrated, so a patient will be seen in the out-patients for example, come onto the ward, seen again in the out-patients; it could be the same nurses that start to see them through." (Senior Manager)

Further developments are described thus:

> "We're doing it now in dermatology. We have a dermatology nurse specialist who sees them on the ward, sees them on the out-patients and outside into the community. We used to have *in situ* twenty odd dermatology beds, now

we've got twelve going down to about ten, but there's more resources going into the out-patients for somebody to be seeing them, so gone are the days now nursing people over weeks really, rather days, and so therefore what facilities are required after discharge or before even discharge or before admission really, it's more concentration on that." (Senior Manager)

The hospital is perceived, particularly by the consultants who control the timing of patient discharge, to be the centre of excellence. Acute trust managers reported the concerns of some consultants who questioned the ability of both district and practice nurses to meet the needs of specific client groups being discharged increasingly early from hospital care:

"We have some clinicians who are reluctant to send patients home to district nurses, because they get so isolated out there. It's a bit like the old night nurses isn't it, you know before rotation, you've got those folks stuck out there who are never updated." (Middle Manager)

In response to the above concerns, one trust in the study had elected to develop an outreach facility for its major elective orthopaedic surgery. In the next extract from an interview with a senior manager a description of the work of the outreach nurse is clearly given, as is a rationale for the establishment of the post:

"(His) remit is really to look at shortening the length of stay. So in his role he's actually got established pre-assessment clinics and visiting patients on the ward giving them further information about the conditions and then following them up at home after early discharge. Should they need to have any sort of intervention he would do so up to fourteen days similar to a midwife." (Senior Manager)

Another senior manager commented:

"What we're trying to do is to provide a comprehensive care package for our patients and I think the difficulty then is how do we integrate that into existing community resources." (Senior Manager)

It would appear that the specific clinical expertise of the specialist nurse is valued by the medical staff and gives confidence to both senior nursing and medical teams in the management of risk inherent in the implementation of these new initiatives. However, a word of caution was offered by a senior director of community services:

"I have discussed with many hospital nurses in the past their ability to move away from the hospital setting and into somebody's home. (They) think they can do that relatively easily ... they feel that nursing on the ward is exactly the same as nursing in somebody's home, which is a very naive view."
(Senior Manager)

It is salutary to learn that in the view of consultants and acute service managers the availability of specialist clinical skills outweighs the benefits of community nursing skills and warrants the considerable cost of providing specialist outreach services across a wide geographical area. A concern about the perceived need and implications of such developments was expressed by a community service manager:

"(An outreach nurse) came to see my staff last week. She isn't even a community nurse. She is not community qualified. The acute trust created this post and she actually goes out to patients' homes - pretty straightforward patients who can be discharged safely with good back up, but nonetheless

she is going in there and is actually visiting as a community liaison nurse ... Certainly at my level and the staff below me are getting very anxious about the developments they see taking place." (Senior Manager)

The following extracts are from practitioners with recent experience in carrying out home visits for the first time. They highlight the stress experienced by nurses moving into the community, and go on to address issues of personal safety:

"Well you are going to the client as opposed to them coming to you, and knocking on doors is horrid at first." (Practitioner)

"Because you are in your area over here and all of a sudden you're not, you're not the person, you know it is not your ward anymore. You are in someone's house." (Practitioner)

"Taking into consideration the process of assessment within a patient's home, and the difference in culture. You are on their territory, if they don't wish to see you, they will close the door. You need to improve your communication skills - what you need to do if you are in a situation where you have a very aggressive client and you're on your own... where do you sit, how do you diffuse aggression." (Practitioner)

"The ability to perhaps diffuse anger. I see that as another problem. Nurses are losing, like Doctors are losing, that sort of protection that they have. They were the people that could move among the community without much fear and having to warn people that there maybe situations where they can't help. Nurses want to help and feel they've got to stick with it. They have got to look towards their own protection." (Practitioner)

Within the hospital setting it can be relatively easy to defer decisions and to refer issues to other more senior practitioners. Indeed many aspects of the hierarchy and organisational structure promote this behaviour. Respondents who work in community settings emphasised the isolated nature of their working patterns, and, from time to time the need to make decisions without discussion with medical and nursing colleagues. They highlighted the accompanying stress which this brings:

"You are one your own, you have to make decisions and you have to be held accountable for that and that feels very different for some of our nurses that are having to move away from the ward or a department, and moving to a community setting." (District Nurse)

"You are on your own as well, I am not sure I like that. And you are not used to being totally alone." (Community Nurse)

"Especially when you've now got the situation that you've got here that you're totally isolated really aren't you. You're not anywhere near the GPs " (Outreach Nurse)

"At ward level it wasn't too bad, you did have other colleagues around you when things were going up the creek but I think in the community because of the isolation of the job you couldn't forget where you and end up with stress without even recognising the symptoms." (Outreach Nurse)

Decision making is often based on experience, but with new situations being faced with more acute patients being nursed in the community, experience may have to give way to untried solutions which must be constantly evaluated:

"A lot of your knowledge is experience isn't it. You draw on what's worked somewhere else; in a similar situation doesn't always work does it, you draw on something else, when that doesn't work you try something else, discuss it with someone else - other groups, other sisters." (Ward Manager)

"Well I think you certainly have to be creative because the work demands that of you, that a lot of time to be able to think on your feet and come up with solutions or at least something to hold on for a while." (Middle Manager)

On the other hand, the need for staff development amongst both district nurses and practice nurses in achieving satisfactory acute care at home is recognised. If outreach nurses do not necessarily have knowledge of community care, community nurses may not have the expert skills of the outreach nurse. The difficulties inherent in fusing the two sets of skills appear, as stated earlier, to be exacerbated by the fact that management of acute and community services in many cases lie in separate trusts:

"There's no doubt that we have a lot of co-operation with the community team, but equally we have a number of tensions. We're being driven by the market, and frankly, you feel that you've got to be one step ahead and your product's got to have that extra couple of widgets that mark it separate from someone else's product." (Senior Manager)

Whether nurses will continue to deal with ever- increasing groups of acutely ill clients both in the hospital and in the community is a question raised during the 'Heathrow Debate' (DoH 1994c) and by this senior manager:

"We've just opened up a new stroke unit this year, and already we're thinking about outreach for nursing and physiotherapy ... What do we need to be doing in the acute unit to ensure that when a patient is discharged they get effective follow-up? How much should we be the people going out and doing that? How much should we be the people supporting, training, developing practice nurses and district nurses, what's the balance between the two? I think there's quite a key role there, because the acute units are becoming more and more specialist in their skills." (Senior Manager)

Whether it will be hospital based outreach nurses or district and practice nurses who, in the long term, undertake the responsibility for such interventions is still not clear. Notwithstanding this the district nurse or health visitor will at some point become involved in the overall management of clients requiring such interventions and will need access to technical and specific clinical information.

Paediatric services are said to be in the vanguard of developing hospital at home schemes; basically utilising one of three models. These are worth exploring within the present context in view of the fact that these services are seen as a test bed for the delivery of acute and chronic adult services. The first centres around the type of outreach described above:

"In paediatrics there's lots of support for the parents so that they can actually continue and look after children at home, and they do that very much from hospital base at the moment. So there's a lot of time in training and teaching and saying 'you really can do it. I am here at the end of the phone if there's a problem." (Middle Manager)

A manager responsible for paediatric services in the whole district trust in the study spoke of a second model to achieve early discharge, based on close collaboration, and proposed by a middle manager in the whole district trust:

> "We can actually get children home faster and they will be cared for in their own homes ... supported probably by nurses with an RSCN qualification in combination with the health visitors and district nurses who are already in the community. So what we want to do is pair the two sets of skills up."
>
> (Middle Manager)

The third possible model is that of in reach, in which community based nurses would give actual hands-on care to patients in hospital. It is here described as an aspiration rather than a reality:

> "It is very idealistic I know but it would be very nice for the community based nurses to be actually involved in that patient's care while they are in hospital. Obviously it would give them a better understanding of what the patient has experienced while he has been in hospital but it would also give that patient a face he knows. Because you come into hospital and you are surrounded by strangers and you may have taken a long time to build up the relationship with your particular community nurse. Then all of a sudden you are yanked out of your own home, you are put in a hospital bed surrounded by all these strange people that you have never met before, all with varying degrees of illness and disability or whatever and you are on your own, a bit like I would suggest being in enemy territory and all your security is gone."
>
> (District Nurse)

Reduction in the Hours Worked by Junior Hospital Doctors

The reduction in the hours worked by junior hospital doctors heralded by the publication of "A New Deal" (DoH, 1991b) had facilitated a review of many areas of work traditionally undertaken by this group. This, combined with the publication of the UKCC's "The Scope of Professional Practice" (UKCC, 1992b) had led to a redefinition of the boundary between medicine and nursing. The report of the Audit Commission on the work of Hospital Doctors in England and Wales (Audit Commission, 1995) stated that:

> "... hospitals differ in how tasks are divided between junior doctors and nurses and other professional groups. In many hospitals nurses and other professionals are now working in areas traditionally regarded as the province of doctors." (p18)

In addition to specific skills and roles, new posts have been created. During the course of the study, we interviewed a 'bed manager' - a nurse manager whose role was developed to relieve junior doctors of the responsibility of finding beds for acute admissions.

Developments are taking place in Accident and Emergency departments, with nurses taking responsibility for diagnosis and treatment of a range of injuries. Nurses are undertaking triage, ordering X rays and assigning patients to doctors for advice or to nurses for treatment. Within defined protocols, nurses, particularly those in community

hospitals, are diagnosing and treating fractures, treating minor burns and scalds, suturing and stapling wounds, administering antibiotics and tetanus toxoid within protocols, dispensing simple analgesics, removing foreign bodies and advising those with head injuries.

In September 1994, after the completion of the interview phase of the study, the Greenhalgh report (Greenhalgh and Co, 1994) was published. This identified a total of seventy nine enhanced/extended role activities identified from the ten sites visited by the research team. The report argued that 75% of junior hospital doctor time was spent on just seven activities:

- insertion of a peripheral IV cannula
- venous blood sampling
- administration of drugs (excluding cytotoxic and first dose) via a peripheral IV Cannula
- urethral catheterisation of male patients
- taking patient histories
- referring patients for investigations
- writing and signing discharge letters

While all of these activities were cited by respondents in this study as forming part of the role of the nurse in the future, four in particular were especially prominent - insertion of a peripheral IV cannula, venous blood sampling, administration of drugs (excluding cytotoxic and first dose) via a peripheral IV Cannula and urethral catheterisation of male and female patients. A fifth skill also mentioned by several of the respondents in this study, although not on the list above, was the recording of 12 lead ECGs. Senior managers were adamant that all practitioners should have these skills within their repertoire in order to demonstrate fitness for purpose and that they should feature in the outcomes of pre registration education for part 12 of the register. Whilst the immediate impetus for change came from the need to introduce the recommendations of 'The New Deal,' there was as previously stated an explicit recognition that the changes provided an opportunity to increase the efficiency and acceptability of the service provided to patients:

> "At the moment the night sisters from both hospitals, are in the planning stages of developing a night practitioner's role which the director of nursing services is involved in, setting up the training scheme for us to go to, and to extend our role into a different job altogether really. They are wanting us to do limited prescribing, learn catheterisation, ECG's, obviously intravenous drugs and venepuncture and verifying expected deaths." (Middle Manager)

Practitioners speaking in the focus groups agreed that the extension to their role provided patients with appropriate treatments at appropriate times, and generally enhanced the smooth running of the ward environment:

> "Well we have now started to give intravenous drugs ... well it is a good idea because sometimes when you are trying to get hold of a doctor and they are busy in theatre or with an emergency etc. the patient tends not to get the intravenous drugs on time such as antibiotics so then you've got a domino effect where they are always behind so you have to give the next dose later on

etc. etc. We are also starting to do venepuncture as well. we have been doing study days on that as well and also ECGs as well." (Practitioner)

Some respondents identified the development in their own practice, of having a waiting list: formerly referrals would have been picked up by other members of the nursing team. As specialist nurses they plan and prioritise care, have their own referral system, and may have their own budget.

However, there was a view from the practitioners that they had been inadequately consulted about the changes to their practice:

"Nobody has actually asked nurses what they mind taking on but you are told, you know, you are going to have to do the cannulas." (Practitioner)

"Also they want us to venesect patients and put drips up and they are looking at reducing the working day of the doctor so that is bound to mean more jobs going to the nurse because that is what the nurses are for. The nurses will do it, how many times have we all heard that 'Oh the nurses will do it'." (Practitioner)

Further evidence of the changing role lies in the claim that nurses are admitting patients and discharging patients within defined protocols. The following statements were made by senior managers in different trusts:

"Extending more in nursing assessment, perhaps we did a few years ago and the scope of practice has allowed us to do that. For example on coronary care we admit people. You know a GP will ring, a nurse will say right, he's got a chest pain, he's got an ECG of this and he must come into coronary care." (Senior Manager)

"Nurses are now looking ... to advise on discharge ... traditionally it's always been the doctor that's done it. So that's changing now. Five day ward - the nurses discharge the patients, because if they wait for the doctor it would be chaos. By the time they got there there'd be too many patients and not enough beds ... they have a set criteria which is discussed between the nurse and the doctor." (Senior Managers)

There is however another side to this coin. For adult nurses the notion of professional accountability is in the forefront, linked together with the need to be assertive. On occasion, nurses would refuse to admit patients when there were no available beds. At the other end of the patient episode, they refused to send patients home inappropriately, and refused to put up extra beds on the ward. "Professional accountability" said one senior manager, "requires assertion skills. Life is a constant juggling act."

Changes in the Assessment Role

The role of the nurse is still described as that of assessing, planning, implementing and evaluating care. Nurses in the focus groups identified three aspects of assessment - observing the patient's physical state, making inferences from behaviour regarding their psychological and social functioning and measuring internal physiological well-

being. From the study it appears that the assessment role in acute settings is, as stated above, becoming broader. In relation to the first of these three aspects, nurses are in some areas clerking patients in, and are thus taking full medical histories and noting previous signs of disease and treatment, such as operation scars. In relation to the measures of internal functioning, nurses are routinely ordering X-rays, ECGs and haematological investigations. Looking slightly further into the future. This senior nurse manager describes her perceptions of the development of this aspect of care:

> "The person will actually be part of the team - supporting junior doctors, working alongside junior doctors. They will work within defined protocols, then will be able to clerk patients in, they will do first level management of patients, they will take chest sounds etc, they will do initial histories, they will prioritise." (Senior Manager)

Another senior manager added some detail:

> "We are currently arranging training for a number of nurses on pre-assessment, on doing chest sound examinations. I honestly think eventually, when patients have an initial assessment it may well be by a nurse ... not just to take over the doctor's duties, but to actually provide a more rounded approach to their care." (Senior Manager)

It was suggested, by a senior community nurse manager, that assessment was a particular strength of nurses:

> "I think one of the main skills, and solicitors are catching on to that I think, are their observation skills, that they don't always realise. They will come out and they will say 'I've just got a gut feeling', and when you go through it with them it's quite specific what it was that they saw, or witnessed , or what was said to them. It wasn't a gut feeling, it was totally justified. And even the third year students can sometimes very quickly identify the source of the problem. I think they are often better at it than other agencies. They have a more holistic view somehow. It's just drawing it out." (Senior Manager)

The Current Care Manager Role

Whilst as indicated above the caring role of the nurse is held to be both key and contemporary, increasingly nurses are managing rather than actually carrying out some aspects of that care. This senior staff nurse describes her role as co-ordinating and managing the care environment:

> "Co-ordinating is quite a large part of our role on (this ward) because I would say the trained nurse has more of a co-ordinating role than actually doing what we would term basic nursing care. Quite a lot of that is delegated to the auxiliary, but it is quite a lot of co-ordination, it is dealing with the multi-disciplinary team. Because of the nature of the ward it is quite important that we do doctors rounds, liaise with all the medical staff and because of the nature of the ward also we have a lot of consultants on the ward at one time so there is quite a lot of co-ordination to be done." (Practitioner)

There are indications of regret in the loss of some direct hands-on care:

> "Unfortunately it seems that our role is being devolved to the auxiliaries because of the nature of our task as trained nurses. They seem to be the ones responsible for bed bathing if required, taking observations and reporting back when necessary, so we do rely on them an awful lot to inform us about what is going on" Practitioner)

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The training and supporting role of the staff nurse was described. She is involved in training other registered nurses, health care assistants and student nurses. It was reported that much of the day to day care was delegated to health care assistants on the whole with a high degree of confidence. The fragile nature of some patterns of grade mix was highlighted by one respondent who stated that it failed to take account of the changing nature of hospital care which is becoming increasingly acute:

> "You need just one acutely ill patient to basically throw the whole ward into chaos." (Practitioner)

This respondent went on to report an absolute refusal to entrust the care of the sickest patients to anyone other than a qualified nurse or a student assessed as competent to meet that person's needs:

> "No because you don't feel they could deal with it, because you've accepted that responsibility and I think in a lot of cases you feel responsible enough to carry it through to the end because it is quite stressful and you would like to avoid piling stress on other people. Sometimes it is unavoidable."
> (Practitioner)

There was evidence that the issue of grade mix was an area of ongoing debate. A senior manager of an acute service indicated:

> "We've got in these health care assistants, but I don't think that means that nurses don't do these things really, because I think nurses like to work very much in the principle of holistic care, and argue that they are better equipped sometimes to deal with what we've always considered mundane tasks because they're dealing with other things at the same time ... I'm not as hung up on that as I used to be. It was very much in the past we analysed things. We looked at this as not appropriate for nursing. This could be handled with lower level skill. Now I'm not quite so sure. I think we've got our skill mix about right now." (Senior Manager)

The senior staff nurse quoted earlier was less confident:

> "I think that is a big change at nursing level. I think there might well be less trained nursing staff per number of patients, because if you have the NVQ trained I think they are going to be responsible for giving the care that we would normally do now and the trained nurses are going to assume a bit more of a managerial role. That is what I feel is going to happen."
> (Senior Staff Nurse)

It was pointed out by a senior educationalist that it is the knowledge base and expertise of the qualified nurse that is require nstigate and to delegate these health care interventions. Nurses will be charged with the primary function of managing the totality of the patient episode. A nurse teacher remarked:

> "Yes, I think we are in an interim period and if you look in the clinical areas a lot of the clinical areas are working on minimum staffing levels so you find a lot of the qualified staff are switching roles, you know, from actually giving direct care to actually co-ordinating in that care." (Educator)

Certainly it appears that where care giving can be delegated this is happening, but it appears that qualified nurses are clear about their unique skills in the care of the

acutely ill patients and it may be suggested that as in-patient episodes become more acute the nurse will return closer to the bedside.

Nowhere is the care management role of the nurse more valued than in the area of discharge. If a twenty-four hour presence is key to the caring role of the nurse, it is also an important factor in this area. Nurses who make referrals to other agencies are in a position to monitor whether the requested action has in fact occurred:

> "There's a clear responsibility on the named nurse. For instance in all of our discharge planning we make it quite clear that the key person to co-ordinate all that is the named nurse, not the consultant. The consultant has overall responsibility for the clinical care and provision but the nurse is responsible for ensuring that all these things that are identified and happen and therefore sometimes they may have to stand up and say sorry, this patient cannot go home. Those things are not in place. In fairness the majority of doctors here accept that." (Senior Manager)

> "The other thing I think is the nurse should more often be primary worker and should refer on to others and not be the person to whom the patient is referred to nurse, I mean nursing lends itself I think to the gatekeeper role rather than general medical practice ..." (Senior Manager)

Negotiation Skills

An increasingly important area of skill which was highlighted by managers, educators and practitioners alike is that of negotiation. Nurses must know when and with whom to communicate, how to locate these individuals and how best to achieve the desired result. An example of the importance of negotiation and communication between health agencies and social agencies is considered by this respondent:

> "There's a blurring of that very grey area as to what's social and what's actual health, so there even is a tri-partite relationship between everybody, because if everybody doesn't communicate and work together, then there's going to be a breakdown of those services and I think in fact nurses are going to have to be more and more, have to be able negotiators, and have a big understanding and knowledge as to where those grey areas are and what in actual fact, what services are provided and where are those services and how to be able to tap into them." (Educator)

> "It's that sort of negotiation, which brings into play knowledge of what's actually achievable and feasible and that's where the nurses knowledge comes in so I would go to the patient and I would know what was achievable and feasible within that particular circumstance and it would be about sitting down and sharing that with a patient and negotiating a reasonable set of outcomes, I would also know what resources were available to me to me to achieve those outcomes and I shouldn't negotiate something that isn't achievable and the outcome of the care plan." (Practitioner)

> "It's actually again negotiating and collaborating the care with everybody and setting those realistic goals and I think there'll be more of that as more patients are being nursed much quicker from hospital to community." (Manager)

It was suggested that both successful negotiation of client services from external agencies and securing the necessary funds and resources within institutions are becoming important roles. At the same time, negotiation skills are also required by

nurses in the changing nurse client relationship in which there is a need to responsive to the needs of an ever increasingly informed public:

> "I think there's probably public awareness about patients rights ... or more where they can complain, that they have the legal right to care, that perhaps they are not getting and I think it's just the free availability of information that is because information, is power." (Senior Manager)

A senior nurse with responsibility for the management of patient complaints highlighted some deficiencies in nurse patient communication. Complaints centre around the failure of nurses to accurately assess clients' information needs, a somewhat prescriptive approach to determining the information given and a failure to reinforce or evaluate the effectiveness or appropriateness of their communications:

> "I think it is something that hospitals don't do very well. I think in some respects maybe we pay lip service to the word communication. Everybody realises how important it is but nobody can actually define it. But it is not reinforced, it is not evaluated, it is not 'am I really sure that the patient has understood what I have told him. Is it really the information that he wants' and very often it isn't the information he wants. We are giving him the information we think he needs to know. But in my opinion and experience the two don't necessarily go together." (Middle Manager)

However, some respondents were of the view that there is evidence of a change in the paternalistic, prescriptive approach to care delivery:

> "I think nurses in the past have been paternalistic, for the best of reasons, you know, they've cared for and about their clients and arising from that they've done things to and I think they're going to need to change to be more, I think of the word advocate but I guess it's not quite the right word, responsive, to be more responsive to the needs of individuals." (Practitioner)

There is support for the view that prescription of care should be replaced by negotiation of care. The next respondent demonstrates the need for this element of negotiation in the type of tasks and care planning decisions that nurses undertake on a day-to-day basis:

> "My first task would be to sit down with the patient and get to know that patient, what their aspirations for this episode of care are, what their needs are ... and to determine with them, you know what the outcomes of care could be, to negotiate with them because they may say well I want ... and that might be an unreasonable hope ... and you might have to negotiate rather different standards ... it's negotiation which brings into play what's achievable and feasible and that's where the nurse's knowledge comes into play."
> (Ward Manager)

The Caring Role of the Nurse

Most nurses, theorists and educationalists, even if they have difficulty in defining care, seem clear about the intrinsic value of caring within the profession of nursing. The promotion of comfort, the use of touch and 'being with' the patient are perceived of as fundamental to the caring dimension of professional nursing. It is, in many senses the hall mark of the profession:

> "It's about the skills of developing the skill of carer, from an art point of view, you know, things like being able to promote comfort, they, being able to in

> actual fact, portray, to be able to get people to relax, to get, understanding of them, to be able to sort of communicate with them, to be able to make them feel confident in your competence." (Practitioner)

It is asserted that nurses are the only group who, in an institutional setting, remain in the vicinity of the patient for the whole of their shift and are prepared to do anything required in response to the patient's needs, even if, in another time and place that response would be made by another professional. In the midst of describing the advanced technical skills required by staff on a medical admission unit, where nurses were carrying out ECGs, performing venepuncture, giving IV drugs, etc, a ward manager made the following remarks:

> "I like to think that I treat people as I would expect my mum to be treated ... initially I like to be behind a screen and listen to them (new staff) with the patient." (Ward Manager)

> "It might be old fashioned these days, but I like them to love. I don't think you can give the care if your heart is not in it." (Ward Manager)

That there is a difficulty in defining the concept is demonstrated by this next respondent. Although the subject is the changing public perception of nurses, there is evidence of a tension between the scientific and the artistic dimensions of nursing in her response:

> "I think the public perception is that nurses are little angels, which is lovely but it is no longer true. I think we are much more scientific now and more professional than that. I am not saying that it wasn't professional to be seen as caring, we are still seen as caring, but I think we should be seen as able to do a lot more for patient care. You ask some of the older people and they would say 'a nurse would do the bed bath, the nurse would change my pyjamas, a nurse would clean my teeth' but they don't take it any further than that." (Educationalist)

The managers interviewed stressed that the developing role of the nurse did not take her away from the patient or reduce the need for a caring approach; it simply changed somewhat the context in which care was given. The point was made that it is as legitimate and possible to communicate effectively and sympathetically with a patient whilst giving IV drugs as when combing their hair. Most respondents expressed the view that the changes which were taking place in the role of the nurse were in the interests of both patient and nurse as the day to day management of care was increasingly under the control of the nurse who was present, rather than of the doctor who was frequently absent and awaited.

There is evidence from the managers that nurses value the development of relationships with clients and recognise potential for promotion of stability which may be a powerful source of therapy and be instrumental in the reduction of anxiety for the client. However, there is a recognition that these 'soft' skills, whilst central to the role of the nurse, are difficult to assess and measure. One practitioner offered the following view:

"We're in a very sort of measurable society ... and these things are much more difficult to measure, because they're more abstract, and I think then it's very difficult, so it's deemed less valuable." (Practitioner)

5.0 ***Key Issues***

5.1 It is essential that pre-registration adult students recognise the importance of pre-assessment and the giving of accurate and timely information in the context of day surgery.

5.2 Educationalists should seek to influence and keep abreast of protocol development within the trusts to which they relate.

5.3 Student nurses should be aware of the professional and legal implications of working within such protocols.

5.4 When nurse managers contemplated the specific and necessary skills that they require of the newly qualified adult nurse of the future, those most commonly mentioned were:

- Venepuncture
- Intra-venous administration of drugs
- Insertion of peripheral intra-venous cannulae

Also raised by some managers were the following skills:

- Urinary catheterisation of men and women
- Treatment of anaphylaxis
- Interpretation of:
  - Electrocardiographs
  - Blood chemistry reports
- Recording a 12 lead ECG

5.6 The development of outreach services offer placement opportunities for student nurses who may observe and participate in the delivery of specialist nursing care in community settings.

5.7 Increasingly, nurses are being required to delegate care, or to prescribe packages of care, in consultation with the patient, which then have to be monitored and evaluated.

For most purposes, the General Practitioner (GP) is the first point of access to mainstream health care. In fact, "ninety per cent of all health care episodes begin and end with the patient's GP" (Glennerster et al, 1994. pp 4-5). According to Maynard and Bloor (1995 p 172) during the 1980's their number increased by over 16% until, in 1992, there were 27,523 GP's and 15,000 practice nurses in Britain, delivering primary care services in conjunction with 12,600 full time equivalent (FTE) health visitors and 19,800 FTE district nurses.

The concept of the primary health care team was born when, in 1974, the district nursing and health visiting services, hitherto part of local authority care provision, joined the family of the NHS. These professionals, based originally in health clinics but gradually co-located with GPs in health centres, had responsibility for a geographical population, were managed within health authorities, and were 'linked' to specified GP practices to facilitate co-ordination. In 1986 the Cumberlege report on Neighbourhood Nursing (DHSS 1986b) suggested that members of the primary health care teams were poorly informed of each others roles:

> "There are many primary health care teams which exist in name, but too often the individual contribution to primary care which the health visitor and the district nurse can make is not well understood by the doctor" (p15)

Glennerster (1994) in a review of the implementation of the fundholding scheme, introduced in the wake of the NHS and Community Care Act 1990, concurs:

> "General Practice has remained a weak partner in the British Health Care System, isolated from the other community health services, which were first run by local authorities and then, after 1974, by separate bureaucracies within the district health authority. This separation makes talk of a "primary health care team" of district nurses, health visitors, other professionals and GP's, a fiction. Good working relationships developed in many practices, despite these organisational barriers but, ... many GP's do not even know what their non-medical colleagues are doing, or which of their patients are being seen by whom." (p5)

In the context of the above statements we present in the following pages a picture of the developing roles of the practice nurses, district nurses and health visitors who work with fundholding GPs. The data derives from interviews with trust managers, GP fundholders and employed or attached nurses; and community nurses who participated in the relevant focus groups.

The Influence of GPs

The service provided by General Practitioners was initially set out in the 1965 Family Doctor Charter, which was updated in 1985 as a result of the work of the new charter

working group. Following the publication of "Promoting Better Health" (1987) and the subsequent reform of the NHS, however, a definitive GP contract which set out the terms of service and remuneration for GPs was drawn up and, despite the concerns of the profession (Chisholm, 1990), came into force on 1 April 1991. Amidst its complex provisions the contract sought to strengthen the work of health promotion and disease prevention by the introduction of quota related payments in such areas as child health surveillance, immunisations and cervical cytology. In relation to child immunisations, for example, the payment to GPs who achieved a 70% uptake was one third of that available to a GP who achieved a 90% uptake. Appropriately qualified practitioners were also to be specifically remunerated for carrying out minor surgery. Also in April 1991, the GP fundholding scheme was implemented. On its introduction, fundholding GPs with over 9,000 patients were allocated their own budgets to purchase a defined range of hospital services which included out-patient and diagnostic services and some elective surgery. The budget allocation also covered pharmaceuticals prescribed by practice staff.

Crucially for this study, in April 1993 the scope of the fundholding scheme was extended to include the purchase of community health services, district nursing, health visiting, chiropody, dietetics, all community and outpatient mental health services; counselling; and health services for people with a learning disability.

All GPs interviewed were fundholders employing at least one practice nurse. During the course of the interviews it became evident that however ambivalent they felt personally about the concept of fundholding in general, they were unanimously positive about the freedom it offered to negotiate better, more flexible services for patients:

> "Well it does mean that if we negotiate strongly, or adequately or fairly, at least if the money follows the patient we can employ somebody else to input that care." (GP)

> "The first thing is that in our negotiations with the health and community trust, they originally offered that we should have a community psychiatric nurse for three and a half days a week ... so we went cost per case for the psychiatric referrals ... she's actually seeing twice as many patients as we would normally have referred to the psychiatrist so our patients are getting a better service." (GP)

> "If you want things to happen in the practice you have to negotiate and try to get what you think is best. " (GP)

One senior manager and nurse adviser to the trust board in an area in which 82% of the population were covered by GP fundholders described the impact on nursing services:

> "Massive, massive within (city), I think out of all the reforms the GP fundholding scheme has had a major impact on the way that I manage and deliver the services. It has been the GP fundholders who have been instrumental in saying, "Can we look at practices here? Can we change

hours? Can we look at grade? Can we look at skill mix? Can we look at the way that the nursing provision is provided across a twenty-four hour time span? Can we introduce quality criteria into the learning disability field?"
(Senior Manager)

In another trust, with far fewer GP fundholders, a community nursing services manager remarked that GPs appeared to be acting to keep grade mix higher than the employing trust, or indeed the major purchaser, felt necessary:

"Traditionally we have found our big purchaser has wanted to address issues such as cost effectiveness and the like through skill mix and pushing us really to adjust the grade mix downwards. GP fundholders, however look at it from a different angle. They seem to tend more to value the higher grade staff and certainly the GP fundholders in this area would be very reluctant to have their grade mix adjusted." (Community Senior Manager)

The increasing influence of GPs has the potential to significantly alter the definition of nursing and the establishment of appropriate levels of qualification and skill. A senior manager in a community and mental health trust portrayed the reducing influence of trusts in developing and defining the role of health visitors, district nurses and some members of the professions supplementary to medicine:

"And I think increasingly we are losing influence in terms of developing them strategically with GPs becoming increasingly more influential. I think the potential is quite clearly there in the future for GPs to employ their own DNs, HVs, etc ... So strategically I think we are getting less and less influential over the development of community nursing services. We have become far more responsive to others. Far more aware that perhaps there are other stakeholders who have just as much influence as we have." (Senior Manager)

The Practice Nurse

In a comprehensive study of the work of practice nurses conducted by the Social Policy Research Unit of the University of York, it was found that 91.8% of those employed in this capacity were registered nurses, 10.3% were enrolled nurses, (sums to more than 100% because of multiple coding,) 24.1% were registered midwives and 3.3% were registered health visitors (Atkin et al 1993, p35). The study records the following specific tasks being undertaken by this group:

"
- immunisation/vaccination
- venepuncture
- auriscopic examination
- using a respiratory peak flow meter
- preparing clinical equipment for a GP
- cervical smears
- assisting GP's with minor surgery
- breast examination
- taking ECG's
- stethoscopic examination of the chest
- ophthalmoscopic examination "

(Atkin et al 1993, p41)

The extent to which the above tasks were being undertaken was, according to respondents in the study, variable. In any case, they were recognised as being in

addition to running or involvement in health promotion clinics, chronic disease management clinics and the carrying out of home visits - the latter normally in relation to the screening of the over 75's which is an annual requirement of the GP contract (of questionable efficacy, according to Scott and Maynard, 1991).

The GP fundholding practices covered in this study were, in line with government legislation, offering a large range of health promotion, chronic disease management, family planning and disease prevention clinics run by practice nurses sometimes in association with other members of the Primary Health Care Team. The clinics were nurse led and followed either nationally set protocols or locally devised ones in line with government guidelines:

> "They have a protocol to follow and they do their set things like blood pressure checks and weight checks, and what have you." (GP)

> "All our clinics are protocol run. They've got detailed protocols so the nurses know when to refer..... We had our protocols ages before there were any national guidelines." (GP)

Two models emerged to typify the work of the practice nurse. In one, the traditional, the doctor prescribed the treatment to be given, and the nurse carried it out. The other picture emerging required the nurse practitioner, working within written protocols, to make treatment decisions before proceeding to organise and give care. An example of the former was presented by one practice nurse respondent:

> "We have a travel clinic ... for anybody that's going abroad...has to see the doctor prior to going and then he then refers them to me. They see the doctor first to ... to find out what injections they need, then once they've see the doctor he gives them a leaflet with all the injections written on and circles them what he needs and then they come back to me and I give them."
> (Practice Nurse)

The GP's and the practice nurses interviewed greatly valued the nurse practitioner model and their vision for the future role of nurses working in this context centred around the further development of this role. It was acknowledged, however, that the success of this transition requires both specific training and support and encouragement from the GP:

> "I think there'll probably be more a shift of power than there is now. I'm lucky because my GPs just let me get on with it. But I do training for practice nurses so I know that that is not the norm really and I know that a lot do have problems and they're not allowed to use their intelligence really. So I feel that that'll have to change if we're to do the job that we're good at."
> (Practice Nurse)

There was evidence of this role shift within the data. One practice nurse gave an example of her freedom to organise her own work and respond to the needs of the practice and its clients in relation to the travel clinic which she runs. When asked how

she would deal with an initial visit from a patient to the clinic requesting the necessary vaccinations for travelling:

> "I give you them there and then ... No GP involvement ... Health protocol says that we will refer to the current guidelines available to us ... we will administer it and the doctors will sign the prescriptions." (Practice Nurse)

The general view from GP respondents was that the nurses who had specialist training in the management of patients with certain conditions, had a more focused perspective and as a result patients were actually getting an improved service. The following respondent illustrated this point in relation to chronic disease management:

> "I would go so far as to say that our asthma nurse knows more about asthma than any of the doctors. Because if you focus just on one condition then you can do. We probably have a different knowledge about asthma, but I think she's absolutely excellent. She's done the diploma .... So the patients are definitely getting a better deal because we've got a nurse who deals with asthma patients and not just us. And we're getting a better deal because there's been a shift in the burden of asthma towards her, or towards being better controlled even." (GP)

> "I do think that people doing certain illnesses following such very well worked out standard guidelines, I should think are better done by one person who actually follows the guidelines." (GP)

The nurses recognised that such specialisation had both advantages and disadvantages. Such was the degree of focus that this imposed access restrictions on patients who were inconvenienced by having to return to the clinic on a specific day to see a particular nurse. Good liaison between nurses was felt to be imperative if clients were to receive continuity of care:

> "I try and get them to come back and see me. For instance, next week I needed ... a man to come back for his blood pressure. He could only come back next Wednesday, unfortunately I'm not on ... so I've told him to come and see my colleague but I've already today told her about this patient because she'll be seeing him so I've let her be aware of what I've written in the notes, etc." (Practice Nurse)

The need for increased delegation to the nurse in the future was a point made by several of the GP respondents. As the work of the GP continues to increase in complexity, with the expansion of minor surgery in the practice and the continually increasing movement of technology into community medical care, it was considered likely that the day-to-day routine tasks would be performed by the nurse:

> "Medicine is becoming more complex and we need to spend more time with patients on certain other matters." (GP)

> "Yes, because a lot of what we do we are over trained for. Treating ear infections and wound infections is a simple basic thing and we have to move away from that really now." (GP)

> "With relation to the acute services I think more work's coming our way isn't it? So I'll have to delegate more but that's fine." (GP)

"I'm doing a lot less of the routine stuff and I see me being able to pass that on to other health workers quite happily." (GP)

"Well the hypertension, diabetes, asthma clinics have gone. Cervical smears, I used to do my own well woman clinic six years ago. I now do almost no smears because the nurses do them and do the well woman clinic. Contraception has been virtually taken over as well, you know the routine stuff and I'm left with things like coils and norplants and things like that, all the more awkward things really." (GP)

Practice nurses welcomed the increased involvement in the minor surgery being performed in general practice:

"In my practice we are semi rural and it's equidistant from three hospitals all of which are at least twenty minutes away and so there is the minor injuries issue and I intend to develop skills like suturing and... with minor surgery in the practice, personally I'm not planning to get involved but I know that there are nurses undertaking responsibility for minor surgery." (Practice Nurse)

Where certain GPs viewed the act of delegation as a positive measure there were certain aspects which gave cause for concern. One GP respondent expressed a regret at the loss of continuity of care due to the delegation of certain aspects of primary care delivery to other members of the team:

"I regret the loss of the personal services yes, you've got far more rewards that way ... if you've looked after them in a progression from contraception onwards, then they know you and they won't call you out at night and they'll take your advice and there's that personal contact where they actually trust you." (GP)

Another, who had a particular interest in obstetrics regretted the loss of ante natal involvement which would come as a result of delegation to midwives following the recommendations in "Changing Childbirth" (1993).

With the impact of the Community Care Act (1990) practice nurses are already seeing more acutely ill patients in their surgeries requiring suture removal, dressings, and advice about aspects of their treatment traditionally dealt with in the hospital. Coupled with this, further extension of the nurses role in conducting physical examinations, patient consultations and making diagnostic decisions is envisioned, along with an increased responsibility in relation to chronic disease management:

"It used to be shared care between GPs and hospital but now a large number of non insulin diabetics are cared for solely by the GP ... with access to the diabetologist you know for more complicated cases. At a recent course we were asked how we would feel about dealing with the insulin dependent diabetics, juggling with their insulin regimes, obviously the stable ones, the more complex ones would still remain under hospital care." (Practitioner)

The Nurse Practitioner

Marsh and Dawes (1995) reported on the setting up of a nurse led minor illness clinic in a GP practice. The rationale was the increasing number of patients with minor illnesses presenting to GP's, attributable in part to "heightened anxiety of parents about their children, the remoteness of older experienced family members ... and less

tolerance of minor health problems" (March & Dawes 1995 p778). Patients were given the option of seeing the nurse. Where the nurse (in this case a registered nurse and midwife) wished medications to be dispensed, she wrote a one line description of the presenting problem and the diagnosis on the back of the prescription, the forms being subsequently "signed by the doctors without the patient seeing them." (ibid p778) It was found that "80% of patients did not return for a further consultation about that episode of illness" (ibid 779) and the report's conclusion was that "trained nurses could diagnose and treat a large proportion of patients currently consulting GPs about minor illnesses provided that the nurse has immediate access to a doctor" (ibid p778).

Early in the study the chief nurse adviser to an FHSA had given notice of the direction in which GP practices were likely to be moving, when he said:

> "The development of clinical skills is going to be a critical area for the future in terms of looking at the development of what was called the nurse practitioner, (although I've moved away from that because it's a bit like beauty - it's in the eye of the beholder). Increasingly that's about the nursing profession how you can use skills better within a practice and nurses taking on those areas of work that were traditionally medicine. And it's looking to provide the right educational skill building blocks within that." (Executive Nurse, FHSA)

The role of the nurse practitioner, who would be able to diagnose and treat certain conditions, was subsequently discussed by a number of the GPs interviewed who saw the new role as an extension of that of the practice nurse, thus facilitating the flow of patients with minor illnesses through the practice:

> "You'll be aware of Geoffrey Marsh's recent paper in the BMJ which is an attractive idea if the nurses see all these patients who come in without an appointment every day. Well one of our nurses is quite interested in the idea ... I think that is the way forward because we can't just be deluged by people with self limiting complaints by and large." (GP)

> "They go out there and they run a clinic. In effect they might even prescribe. They'll come to us and say 'Can I have a prescription for so and so?' So they are now actually becoming practitioners. Patients come to them with their asthma but they mention other things as well, whilst they are here." (GP)

> "You've got to try to trickle jobs down to the most appropriate skill level and that's where the nurses come in. Well in the future I think more and more nurses will be seen as the point of first contact for patients." (GP)

Another of the GPs interviewed was in the process of training a number of his practice nurses to take on the role of nurse practitioners thereby "addressing the acute problem with patients rather than the chronic problems". This particular practice had identified four areas which needed to be addressed:

> "One is simple rashes, another is ENT problems, another is urinary tract infections and the other one is vaginal discharge." (GP)

The areas were chosen both because they represented a large proportion of the work being carried out in the practice, and it was reported that were well within the scope of the trained nurse practitioner.

The practice nurse was highly regarded by all respondents and indeed was credited with performing what amounts to clinical diagnosis:

> "You've got to give them credit. In fact they probably underestimate themselves. The phone goes and they say "can you see somebody with such and such" ... and their most important function is being alert to when things are going wrong and saying "look the situation isn't improving" ... As a GP I've got to know when somebody's ill and somebody's well and they're the same." (GP)

A GP in another geographical area was supportive of the concept of patients self referring directly to the practice nurse who is performing the role of a nurse practitioner:

> "They do the adolescent clinics and of course a spin off of that ... girls will come and see them, and certainly our practice nurse has had one or two people come directly to her about post coital contraception, pregnancy, the pill ... So she would initially see them". (GP)

Three of the practice nurse respondents in the study described seeing patients as direct referrals, the option having been given to the patient by the receptionist. At times this was recognised by the nurses as a way for a patient to access a busy GP if no surgery appointments were available:

> "Usually the receptionist can ascertain from them when they make an appointment what it's for, if it's something that she feels we can deal with and usually travel falls into that category, cervical smears, family planning, dressings, minor injuries, ear syringing. To quite a significant extent people who ring up for doctors appointment can't be fitted in and are offered a nurses appointment. A lot of patients seem to recognise that we're a sort of back door, they know we've got a doctor in the next room and if we want a second opinion they'll see the doctor that way if they need it but quite a few who've actually wanted a doctors appointment come to see us and are quite satisfied with what, you know, the treatment they get or the consultation."
>
> (Practice Nurse)

The FHSA respondent interviewed supported this view of patient satisfaction, pointing out later in the interview that the nurse was actually developing a different service - not necessarily cheaper - because consultations were, by and large, longer:

> "But the patient actually likes it. Patient dynamics in primary care is quite fascinating. The public perception of the GP is someone who is harassed, short of time, must get in, get the problem solved, get advice and out the door because the doctor's busy. Where nurses are running minor illness clinics or running their own surgeries in terms of minor illness within protocols, the patient feels much more comfortable to explore a range of issues and the consultation takes longer ... You're not developing a cheap doctor. The patient is quite discerning in terms of the skills that they want and they feel that they can spend time with the nurse." (Executive Nurse, FHSA)

He went on to add that consultation skills would be an essential part of the training of practice nurses in the future. This particular manager had been working closely with

his local College of Health in developing a degree pathway for practice nurses, and shortly following this interview, succeeded in achieving regional commitment for funding of this course from Working Paper 10 funding. Funds had also been identified to create a network of supervisors/assessors to support this development.

Nurse Prescribing

The concept of nurse prescribing was originally the subject of a recommendation in the Cumberlege Report (DHSS, 1986). After the necessary changes to the legislation were put in place in 1992, the ENB required that preparation for nurse prescribing be incorporated within the district nursing and health visiting curricula (ENB 1992c). This regularised, according to a senior trust manager in the earlier interviews, a situation which had existed for many years:

> "In primary health care teams there's very much GP's letting nurses, particularly DN's take the lead in determining what should be prescribed for patients but then actually prescribing it. But I'm sure the GP just responds to everything the DN says. I think there's informal prescribing in the community by nursing." (Senior Manager)

This view was upheld by all the GPs interviewed who believed that, working within guidelines and protocols, nurse prescribing would be of great benefit within primary care. The present system, where nurses have to "chase us for a signature" was seen as unnecessary and time consuming:

> "They all do it and it's just a farce that we have to sign them. Particularly for dressings." (GP)

The prescribing of creams and dressings for ulcers, inhalers for asthma sufferers, vitamins and iron tablets were all seen as areas in which the nurse could operate safely and efficiently:

> "I mean if somebody's got an ulcer ... I don't know anything about ulcers. I mean I check the medical side but as far as what to put on it I don't see that as my role." (GP)

> "She does all the inhaler techniques, which inhalers, you see so she would say 'This child is able to use this device' so that's what we do." (GP)

> "... and the dressings, if I've got somebody with a leg ulcer I say to the nurse 'here's your patient, they've got a leg ulcer. How would you like to treat it?" (GP)

In common with the views of the GP's all the practice nurses interviewed welcomed the ability to prescribe treatments for their patients:

> "I think it's just time. I could have a whole room full of people out there and I'll get somebody that comes in that's got, I don't know, a breast lump or an ear infection, and I say right, you know, you obviously need a ... you know, an anti-biotic or something. And I'll even do it, you know, I'll write it out and print it out, and go over there to get it signed. But I'm stood outside their room waiting for them to finish with their last patient to get this signed so this person can have it ... I want them to be sorted there and then rather than feeling that they've to come back for a prescription." (Practice Nurse)

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Using extended role skills as described earlier, diagnosis and treatment decisions were taken by the nurses. The following illustrates the extent to which the practice nurse can operate within existing guidelines:

> "We've got an over-the-counter directory. We can advise them on the appropriate medication they can purchase from chemist, if they're on free prescriptions we can get computerised printout prescription for them, discuss it with the doctor after surgery if he agrees he authorises the prescription ... and to a certain extent antibiotics, we have protocols for tonsillitis and we issue a prescription and ask them to go or send it to the chemist ... so they get medication that way." (Practice Nurse)

One respondent expressed the view that current nurse prescribing powers would be inadequate in view of the work she was already currently doing in her practice:

> "Prescribing stuff that ... the nurse practitioners prescribe, it's no use nor ornament to me ... most of it's ... over the counter stuff anyway. It's asthma drugs, diabetic drugs, antibiotics, oral contraception that I'd be interested in." (Practice Nurse)

GP respondents whose practice nurses were operating a minor ailment clinic were keen to see nurses prescribing antibiotics, but it was recognised that this required particular specialist training and the drugs and conditions involved would be determined by local need:

> "And I suppose for something like antibiotics and once you get into more that sort of thing it would need to depend on the training of the nurse." (GP)

> "I think it would have to be a very local person based thing, about what they could sign and what they couldn't sign. At the moment, you see ... she's writing the prescriptions for things like antibiotics as well, and what she does, she gets a prescription printed up and she writes on the side slip why she thinks this person needs antibiotics. We sign it if we think it's reasonable, and if she's not sure obviously she calls us." (GP)

The Role of the District Nurse

Respondents responsible for district nursing in the community reported that, over the previous 4-5 years there had been a review of skill mix in the community. The traditional picture of a pure-bred cadre of G grade DN diploma nurses was giving way to the creation of a team of staff nurses (D or E grade) district enrolled nurses and health care assistants. The change had been handled gradually and opportunistically and at different rates in different areas. The team leader is the G grade, who has a contractual responsibility for assessing clients and allocating patients to other members of the team. (One trust reported that even here, they had actually broken ground by appointing as a G grade district nurse a practitioner who did not possess a DN qualification, but, by virtue of experience, and the completion of a nursing degree was deemed to have the required skills.) The FHSA respondent below offered an answer to other managers who were beginning to query what it was that the district nurse brought to an assessment that other registered nurses did not:

> "I think also you'd actually have to become more self reliant and an autonomous practitioner within the community than in a clinical setting where

you have that sort of back up available. You've actually got to be networked and to have the skills to network on an inter-agency basis."

(Executive Nurse, FHSA)

A district nurse described her role as the initial assessor of care needs who would then retain responsibility for the care delegated to other members of the team:

"I'd say it's changed already over the last ten years and the role, includes a lot more management skills organisation, initial assessment of work but then handing over to other people or referring to other agencies whereas before we'd probably taken on. the work ... (We) delegate and yes, I mean, deciding on and prescribing the care, having to be very careful I now have to think a lot more, should I be doing this or should I be referring this to somebody else and sometimes you worry that you might refer something to somebody else that maybe you should have kept yourself, it's quite difficult sometimes to make that decision."

(District Nurse)

According to our respondents, the nursing skills required were equally distributed amongst qualified staff, the only exception being that the district enrolled nurse did not handle controlled drugs, and therefore could not re-charge syringe drivers. Managers were beginning to question (although not as vociferously as their mental health counterparts) the future, in the long term, of specialist community qualifications. One remarked that much of the content of the traditional DN diploma course was now contained within the Project 2000 course. However, there was at the time of the interviews little experience of employing Project 2000 nurses in the community, as managers had tended to employ experienced staff nurses, and, as the posts were popular, "had their pick." One teacher reported a recent appointment of a Project 2000 student to such a post, but at the time of interviewing managers, no specific feedback was available as to the suitability of their skills base. In relation to preparation for part 12 of the register, the only specific views offered by community nursing service managers were that IV drug administration, venepuncture and male and female catheterisation should be in the repertoire of all nurses. As noted in Chapter 3, GPs had hitherto resisted the introduction of staff nurses rather than G grades, but one respondent speaking from the FHSA viewpoint, remarked:

"Particularly in HV and DN with Project 2000 we are beginning to see an expanded range of skills in the community. I think we have to look at how we use these people in the future and what skills they bring. Where's the added benefit of those. A number of practices are now looking at a range of skills within the practice, where they traditionally looked at the F grade or the G grade."

(Executive Nurse, FHSA)

However, he sounded a note of caution in relation to the immediate deployment of newly qualified Project 2000 within the community setting:

"I am concerned about nurses coming straight from a Project 2000 background immediately working in primary care without that being underpinned by proper supervision and we haven't a network of supervision in primary care to cope with that."

(Executive Nurse, FHSA)

The Changing Face of Primary Care

As to the profile of work being carried out by community nursing teams there is a need to bring together comments made on the impact of the changing profile of clients in the community and to relate this to the work of district nurses and health visitors. A chief nurse adviser to the board of one of the trusts in the study made the following comment:

> "We're already seeing quicker discharge of very premature infants, of women who have had children and of people who have had major surgery, so again that is being picked up within the community setting. Some of the chronic cases that were in the past dealt with in hospital, enteral feed to parenteral feeds, children on long term oxygen therapy, cystic fibrosis, etc, again are being transferred from the hospital, into the primary care setting. The big area for us is on the care of the dying, and the terminally ill, and more people wish to be nursed at home with their relatives, but using more hospice care for respite, rather than coming back into the hospital." (Chief Nurse Adviser)

The district nurses confirmed that their traditional role is changing from that of care giver to the chronic sick and infirm to that of caring for more acutely ill patients and acting as care co-ordinator:

> "Early discharge of patients from hospital means that we have people at home who would have previously still been in hospital feeling quite ill and perhaps feeling quite alone and abandoned ... I had a lady recently ... she'd had a breast reconstruction and the wounds to her abdomen and also to her breast were really badly broken down and required a twice daily dressings ... previously someone like that would have been in hospital until they were much better but now they come home and it can be quite frightening for them because, they feel quite ill and if they live on their own as well."
>
> (District Nurse)

As the impact of the community care act is felt not only are patients discharged early from hospitals but patients who may have traditionally been admitted to hospital are being looked after at home:

> "I had a lady recently, she's in hospital now but has end stage cor-pulmonale ... woman who's getting totally breathless just walking to the toilet and back yet was at home rather than being admitted to hospital because, OK, there's nothing particular. I mean, they can give her some drugs but ... there's nothing life saving probably they can do. So more people I would say are staying at home." (District Nurse)

Respondents suggested that as nurses in the community are increasingly charged with the continuity of care in complex care scenarios, such as stroke rehabilitation, it is evident that the skills required are becoming more complex. Many respondents made reference to the highly technical nature of care with which district nurses will have to deal. Skills required range from the intravenous administration of cytotoxic drugs to management of patient controlled systems of analgesia, parenteral feeding systems and so forth. One GP respondent expressed his views for the future of community nursing, and the potential implications for his work arising from the increasingly technical nature of client care in the community:

> "I think nurses do a lot of the terminal care and pain control that was always done in hospital. I think in the future you're going to get intra venous feeding

> ... care of cystic fibrosis children with IV lines to maintain, IV antibiotics, care of neonates more in the community. You're going to get care of adult patients needing regular IVs , chronic chests and the like, bronchitis patients. Inevitably there are going to be complications then and it's going to fall back on us." (GP)

Also in keeping with this district nurses reported that they were providing home care to patients with complex technical equipment or supporting and administering intravenous therapy to patients in their own homes:

> "We're looking into IV training and Hickman line training because people ... coming home, they're on chemotherapy ... and we've looked at what impact that's having on the service and the one thing we can see in the very near future, because we're already getting them home. In other areas of the country there are actually district nurses are giving IVs to patients at home."
> (Middle Manager)

It was in recognition of this increasing trend that in 1994, the ENB published the final report of the working group on "Developing the role of the district nurse in the administration of intra-venous therapy in the home" (ENB 1994f). It recognised that DNs were being increasingly required to manage Hickman lines and portacaths for clients requiring long term therapy (such as those with HIV and AIDS). One year later, the publication of the NHSE letter EL(95/5) "Purchasing high tech health care for patients at home" recognised the implications of funding packages of care such as CAPD and total parenteral nutrition and decreed that these should be part of the formal contract between purchasers and providers. The extent to which these areas of care are being delegated to other members of the community nursing team other than the leader is a subject which requires in depth study.

Further changes to workload patterns were also highlighted. District nurses reported that they were receiving requests to perform 'one off' visits to patients without specific nursing needs but whom hospital staff recognised as being at risk:

> "Quite a lot of one off visits, suture removals, and also we get people who come home from hospital, obviously the ward staff are quite concerned about because they feel they're going home quite early on and there might not be particularly anything to do but they ask us to call round and check them, well, you go round and check them and OK they're reassured to see you but in fact there's nothing particularly to do for them but you've got to go all the same."
> (District Nurse)

> "... if you look at the other aspect of community care people are kept being kept at home longer before they're being admitted to hospital especially if they've got chronic problems." (District Nurse)

The GPs recognised that they were using the district nurses differently in response to the changing nature of care in the community. Whilst district nurses had historically performed a reactive caring and curative role, it was said that increasingly they are becoming more involved in prevention and claims were made that this has caused some overlap with the role of the practice nurse:

"The role of the district nurse is changing. She's doing more prevention, and I think you're finding now that maybe within each primary health care team practice nurse and district nurses have different roles and it varies from area to area. It varies from the skills they bring in." (GP)

The educational role of the district nurse in relation to the management of acutely ill patients at home was also emphasised by many respondents. Patients, families and carers require education in the management of complex hardware. Nurses working in the community increasingly require the knowledge and skills to use and train others in the use of a diverse range of technical equipment. To support families and clients in this situation requires confidence in practice, the ability to assess and manage risk and an ability to gauge, with some degree of accuracy, the clients' and carers' capacity to manage technical equipment in the relative isolation of their own homes. As the following account, taken from the focus groups, shows, teaching patients and carers and evaluating their expertise does not ensure the continuation of quality care delivery:

"It is always a bit of difficult area where we have taught a parent to do something like IV drugs at home and then you get to a stage when do you assess that their standards are the same that you actually taught them. We tried 3 months, we tried 6 months and I mean being realistic they all cut corners and developed bad habits. It is very difficult where you should actually go in and reassess the parents, we have always found that a difficult area from that point of view and putting responsibility onto parents when to increase the morphine with a syringe driver ..." (District Nurse)

Professional carers, too, had education and training needs and these to some extent were being met by the district nurses. The staff of nursing homes, who were only occasionally required to take blood samples from patients required help from district nursing services. In one trust in the study a change to the current service contract was being negotiated to allow DNs to give this support officially.

For the district nurses there were issues pertaining to the changing nature of the care tasks being delegated to health care assistants and to the management of the health and social care interface. Both social services domiciliary carers and health care assistants were reported to be giving care to patients with complex needs as the following quotations indicate:

"The health care assistant that works for me, her whole day used to be practically taken up with bathing. Now we've got strict bathing criteria and most of those people go to social service. Therefore we've expanded her role in that she'll do very minor dressings, she'll visit patients who previously we would have visited and I just see that there'll be more expansion of health care assistant's role and there'll be a lot less trained staff in the community, not that I'm saying that I think that's a good thing but that's the way I see it going." (District Nurse)

"There might be an elderly person with arthritis, incontinent, that needs washing, getting up in the morning, dressed, given some breakfast. A domiciliary carer will take care of that, and then perhaps we pull out altogether, but they contact us if there's any problems." (District Nurse)

> "A lady with MS she's also had a stroke and is going to need a lot of care ... in days gone by I can remember when that patient would have been totally looked after by the district nursing service, now we'll have a meeting and a package of care will be decided between social services and ourselves."
>
> (District Nurse)

In Chapter 4 the debate around the role of the primary health care team in relation to mental health nursing was highlighted. In one of the trusts in the study consideration is being given to the role of the district nurse in meeting the physical and mental health needs of the elderly. Seven district nurses with RMN qualifications are involved in the development of this service. The same Trust was considering two other key developments. One related to the creation of nurse managed beds in community hospitals. The second was a response to the national dispute over night calls in which GPs are currently engaged. The vision was for the development of primary care crisis centres centred in community hospitals and staffed overnight by district nurses who would provide a home visiting service in emergencies. This would be backed by the minor injuries service also provided from the community hospitals.

The Role of the Health Visitor

It was reported that the role of the health visitor was evolving differently in different parts of the country in response to the requirements of the respective Health Authorities. The commissioners in one of the areas of study were themselves engaged in determining what the role should be, informed by such strategy documents as "Vision for the Future" (NHSME 1993a) and "Seen but Not Heard" (Audit Commission, 1994b) and a consultation paper was produced which defined essential (including child health and surveillance), desirable (including immunisation, bereavement visiting and housing assessments) and public health (including contact tracing for TB).

Commissioning contracts in some parts of the country are perceived by some respondents to have concentrated the work of health visitors on child development screening and health promotion, rather than developing their role as family visitors giving care from "cradle to grave." Certainly there was pressure to provide measurable data by which the effectiveness and efficiency of the service could be demonstrated. How much of a culture shock this constitutes is indicated by the Audit Commission's findings:

> "Health Visitors at authorities spend about 30% of their time working with families with young children, excluding time spent in health surveillance checks, but it is not always clear how or why these families are targeted ... Health Visitors were also unable to summarise the needs prevalent in their own caseloads ... (They) were unable to demonstrate how they set priorities."
>
> (Audit Commission, 1994b pp 22-23)

Further pressures moulding the role and function arose from GP fundholding contracts. A general view emerged that the role of the Health Visitor had been restricted by the contracting process and that this had led to feelings of disillusionment amongst many. The contracting processes were seen to have constrained the professional autonomy of the practitioner by stipulating the number of home visits to be done to each family:

> "The health visitors are tied very strongly to the child surveillance that they are contracted to carry out and the visits that they do to families with very young children has been really reduced ... to the point where a health visitor is expected to do a new baby visit; the baby is expected to have a developmental screening at six weeks by a Doctor, so the health visitor then doesn't visit again until seven months to do developmental screening and baby hearing tests. Whereas in the past you would have spent quite a lot of time in that early months developing a relationship with the mother in the hope that the family would contact her should they need her in the future, and to sort of give some anticipatory guidance, I've noticed that that seems to have slipped, because of the purchasers contract." (Educator)

> "She goes to the home to do a seven month visit with a set of scales a measuring board - it's very different from what I did five or six years ago where the child's development was assessed as part of a conversation with the mother but it's very geared into things like; 'hips are checked', *ad nauseam* very much a physical check." (Educator)

It was confirmed in the interviews with the majority of GP respondents that their continued perception of the role of the health visitor centred around the care of the child:

> "Our health visitor does our paediatric surveillance and then does the menopause and the adolescent clinics with the practice nurse ... Really her role in this practice is the children." (GP)

This perception was in turn confirmed by health visitor respondents:

> "I see our role as ... 90-95% ... with under pre-school children and work within a minimum package...A local trust minimum package. The amount of visits or the amount of time, you know to make contact with the parents, most of that is not really at the home now, it's more at the clinic where you offer them developmental checks.". (Health Visitor)

In one practice, the GP reported that the health visitor was actively involved in ante natal as well as post natal care. This was perceived as valuable as her approach was different from that of the midwife and would provide support for the couple and a continuity of care from early on in the pregnancy:

> "We try to do 2 visits now for the health visitor one early in pregnancy, very early in pregnancy so if they miscarry she's met them, and a second one, which is an evening visit and she meets the husband because what we are trying to do is to have our health visitor meet every couple. Well starting off anyway with all the first timers. So that's the idea, so that's why I think she needs to be at the meeting, because she won't be involved in the antenataling and I see it as a totally distinct role that she's going in at a different angle." (GP)

Overall, however, many of the GP responses revealed the high value placed on technical, traditional nursing skills; the more facilitative professional competencies of

the health visitor being paid scant attention in the interviews. This raises important questions which are well recognised by the profession concerning the balance of factors which are measurable and those that are important. One GP expressed a controversial view:

> "Our health visitor when she first came didn't do immunisations. And that's one of the things I think about the contract was health visitors woke up to the fact that if they wouldn't do immunisations, no-one's going to employ a health visitor for after all if they couldn't do an immunisation they were only a counsellor." (GP)

One educator, a health visitor who maintained good practice links, expressed some discomfort at the expectations of health visitors in relation to home immunisations. Some mothers, she suggested, exercised their right to refuse immunisations by failing to turn up for appointments and in these cases a visit may be perceived as a form of coercion:

> "If it's a genuine case where they really can not get to the clinic, then the health visitor needs to be able to assess this, but I just wonder about, if we turn up on the doorstep with a needle and syringe, how many mothers would actually ..consent to her if they don't really want to. and as long as their choice is informed, they should be honoured to decline." (Educator)

There was some discussion around the ability of health visitors to assume responsibilities involving any element of 'hands on' nursing care with concern focusing on the contemporary nature of clinical skills. A proportion of the health visitors interviewed believed that such activity was not a legitimate part of their role:

> "Because I was saying if I felt confident I would go and do that, I'm sure dressings have changed an awful lot since I did dressings so I think you would have to be aware that you are accountable anyhow, so you'd have to be aware the you'd have to know what you were going to do and not do if you didn't think you could do." (Health Visitor)

For those professionals early discharge from hospital of young children requiring on going therapy or treatment at home was viewed as *another* nurses responsibility. i.e. that of the specialist paediatric nurse. The health visitor's function in these family situations was perceived as the provision of support to the family. However, one newly qualified health visitor expressed disappointment that she was not asked to provide practical nursing skills to a young child following discharge from hospital and viewed the reasoning behind this as being that there was a lack of understanding from the hospital staff about the role of the health visitor:

> "A child was discharged from hospital on Friday. I think they wanted a health visitor to go in that day to have a look - I think he might have had a swollen testis, or something - to make sure that he was PU-ing OK and his swelling had gone down. He had a suture line as well, I think it might have been hernia, but they'd made out another referral to the district sisters to take the suture out on the Tuesday, and really we could have actually done that. But they didn't see that as our role in the hospital really, to take out the suture, whereas I feel that you know there's no need to make another referral when it was quite a simple nursing task to take out a suture. You know the function that the people see of health visitors, nurses in hospital." (Health Visitor)

Another health visitor suggested that this lack of clarity of role and value of competencies was not unique to the nursing and medical professions but that clients also had a confused view of the profession:

> "Clients do not view us as having a nursing background which I find quite disappointing,. We try to put that across to clients but they see you as that, because you haven't got a uniform on and they can't see past that barrier. I feel that they see us more as a sort of mini social worker as such really ... more there to check on the child, and that parents aren't abusing that child in anyway, rather than as a health worker to make sure that that children are developing within the normal milestones, etc." (Health Visitor)

There was a feeling that the most important aspects of the health visitors role had been eroded, for example carrying out home visits to families, providing behaviour management programmes and offering support and advice to families in order to prevent crisis situations developing. Coupled with this the impact of increasing numbers of child protection issues requiring reports and liaison with social services left health visitors feeling frustrated and at times professionally isolated:

> "Paperwork and the volume of work. The numbers just go up and up and up. Caseload numbers increase because ... when you're having regular contacts with families you keep on top of the problems. Now it seems to be crisis work. When you do see them you haven't seen them for perhaps six months and they come in and all the work you thought you'd got on top off has perhaps fallen apart. The behaviour management's collapsed. Instead of being able to go in periodically and reinforce it, everything's fallen apart and so you start again from scratch and it's such hard work really. You're not able to do the maintenance work in between the contacts." (Health Visitor)

The restructuring of social services has also introduced added pressures to the health visitors as illustrated in the following quotation:

> "We used to be able to have a quite clear divide and a good working relationship with social services so if there were obvious social problems that were impinging on health we could make referrals to social services and they would pick up a lot of that, but now the social services office in this area is closed so we do a lot of the social work referrals. Things would be like children on the child protection register, we do a lot more of the surveillance work with those ... I think the social services must have had cuts as well so when you go into case conference now or the review, looking at like who can do the most ... of the work for you, popping in and seeing how things are going and that's falling to us more and more. Certainly in this area." (Health Visitor)

Respondents confirmed that helping families access social support remains a legitimate part of their role and great emphasis was placed on in dealing with families with child protection issues, a role largely ignored by the GP's and mentioned by neither practice nurses nor district nurses.

None of the Trusts within the study employed staff nurses in support of health visitors. However, some of the developmental screening work was being carried out by nursery nurses who also offered administrative support to the health visitors.

Communication within the Primary Health Care Team

The issue of base has long been an important factor in patterns of communication between members of the primary health care teams. By no means all teams have been co-located. However, since the advent of GP fundholding a number of the fundholders interviewed had taken advantage of the situation to move into larger more suitable premises. It was confirmed that this had greatly facilitated the communication process:

> "So people who were members of the team before, could all sort of be with us at the same time ... physically present which I think is a tremendous advantage because you can spin ideas off each other." (GP)

> "It's all centred around the primary health care team which is based here ... the community services are actually in the same building as us, which is a very useful thing for communication." (GP)

Where all the nurses were based under the one roof the communication links in the practice had greatly improved and was commented upon by all the respondents. In the one practice where the trust nurses were not based on the same site communications were perceived as poor and the greater potential for role overlap identified. It was confirmed that there were inherent difficulties communication between professionals whose work entails visiting patients and clients at home:

> "I think it is very difficult when you are working in the community to actually get hold of people, we are forever leaving messages with each other, you know the social worker, health visitor. We always seem to be chasing one another" (District Nurse)

The GPs reported that they dealt with the issue of team co-ordination in a variety of ways involving formal and informal meetings, discussions over coffee and chats in the corridor:

> "I mean the team meeting is not a sit down and everybody be quiet it's everybody talk like mad to each other to do the communication they need to do." (GP)

> "The team meeting is every day, for everybody who's on the premises, the practice nurses, the doctors, the district nurses...its a business coffee break ... The CPNs, because they're not based here, make a special effort to come in once a week to have their coffee here with us and they'll come in with a list of things ... So it's individual interactions all happening in the same room... and everybody knows that we'll be here, and everybody will be here so if I want to speak to a district nurse I know when I can catch them ... Whereas the formal three monthly one, is a much more formal thing where everybody sits and listens to each person as they sit and talk and its about policy, planning." (GP)

Criticisms were heard from all nursing respondents that communications with GP colleagues could be sporadic. Highly valued were those practices who regularly held primary health care team meetings.

Care Management

Whilst in the view of the GPs the doctor was seen as having the prime role of co-ordination within the practice setting, a number expressed the view that in relation to the co-ordination of client care, the district nurse had the key role. It was she who acted as a team co-ordinator, arranging for health and social care to be delivered:

> "I (GP) found a man with rheumatoid arthritis on his own. (The district nurse) goes round and sorts out the welfare rights as well, and all the medical needs ... then she leaves the nursing form at the house and decides how often he needs a nurse and whether he needs a bath nurse, social services help." (GP)

As described in Chapter 5, however, the dual responsibility of health and social care agencies in relation to community care ensures that this co-ordinating role is a difficult one. A senior nurse manager explained:

> "But also there is a communication problem a lot of the time because you find you go in and then actually someone else is actually doing that, or they have got a family aid in or whatever you call them to do the same sort of thing that I might ask the nursery nurse to go in and do. And it is only because you didn't know, because they didn't tell you." (Senior Manager)

And even inter-agency transfers of information are not without difficulty:

> "You're very, very isolated now. Often children are coming to school without records so you're seeing children you know very, very little about. Or you might go to a case conference and the records have disappeared, going from clinic into child health." (Health Visitor)

The GPs interviewed were particularly concerned about the lack of clarity surrounding the processes involved in inter-agency communication. One GP commented on the interaction with the social care team:

> "Well we can refer to them directly. They're changing all the time, and I would really like to know how their system works. There's not enough liaison really with the social work people ... It's virtually non existent." (GP)

Health Needs Assessment and Health Promotion

The issue of health needs assessment of whole communities was stressed by a nurse educator with a community specialism:

> "Nurses need insight into the way families and communities operate, so it's, knowledge of society's needs, a knowledge of community, a knowledge of people." (Educator)

Such involvement will require the nurse to make contributions to systems of purchasing services that are responsive to local needs and to develop partnerships with other organisations such as social services and local authority services. It is suggested that nurses working in community settings should take on board specific objectives relating to the Health of the Nation targets. These stress the need for ensuring that the pre-requisites for health exist and, in addition, the importance of health needs assessment and health promotion in international, national and local communities. That this area is still, despite the publication of the Health of the Nation Targets, a relatively poor relation within the NHS is stressed by this senior manager:

"I would hope, that the Department of Health really focuses on primary care more than just paying lip service to it. At the moment the NHS is still curing people, it is not preventing at all, which is why there's a mad dash around of Trusts across the country to appoint more consultants, instead of appointing more paramedical specialities, because if you did that you wouldn't need to have all the people in to have their leg amputated, because you have prevented that. I think we need to push much more than we have both locally and nationally on health of the nation targets, because I don't think we've done that specifically at all." (Senior Manager)

Adult nurses working in the community elaborated upon their health promotion/education activities and the wide variety of client/patient groups to whom this was delivered. They described using informal one to one teaching or more formalised presentation skills to larger groups. Such group teaching activities were not a feature of the work of adult nurses in institutional settings, but are common to many mental health practitioners and to all nurses working in community settings:

"Part of health care is health promotion." (District Nurse)

"There are a certain type of skills that you still maybe need to health promote ... when I've discussed this with qualified staff in clinical areas they have said yes the education provided them with skills for health promotion, but they felt they needed the basic skills more." (District Nurse)

The provision of information regarding health issues was a theme picked up by several of the GPs interviewed. It was stressed that the charitable organisations and library services ran excellent services which, being locality based worked very efficiently. One practice had employed a practitioner to carry out this service but ran into difficulties because of the restrictions of a practice based service:

"We did have somebody employed to do it at one point, it was quite successful but because she had to restrict herself to our practice population it didn't really work very well. " (GP)

Financial Issues and Budgeting

District nurses spoke more than their hospital based counterparts about the need to understand how care was organised and funded. They come face to face with issues of securing funding for residential and nursing home care, and some confusion was apparent in the following discussion of the mechanisms:

"I don't think I was ever asked before to recommend if someone was suitable for a nursing home." (District Nurse)

"I mean you could say to the patient you will be better in a rest home or something like that but you didn't have to fill in the forms, and get the money from the Trust or anything like that." (District Nurse)

They demonstrated increasing awareness of cash limits, and of the need to understand the requirements of the contracting process:

"I mean everything you have to think about is financed by somebody." (District Nurse)

"Having a knowledge of purchaser and provider that's all very new to us isn't it." (Health Visitor)

"That's just happening with us, with special needs children and I have the legal accountability, that if something is written down it has to be achieved and if it is not achieved within that time span then the Health will be asked to budget."
(Health Visitor)

"It is partly to do with finance isn't it, the contracts and things" (District Nurse)

"I think the business role like everything else that has happened has taken precedence over the clinical role." (District Nurse)

Role Overlap

For the primary health care respondents, the overlapping of roles did not appear to be a problem. There was recognition of the potential, however, and nurse-led systems to prevent this ranged from a formal nursing clinical meeting once a month to informal ad-hoc meetings in the surgery. Regular contact with other nursing members of the primary health care team was valued by all respondents. Role was not perceived as a problem as long as all the nursing team members were aware of each others particular skills and remit:

"Sometimes it is very clear cut, that if a patient can physically get to the surgery then we will take care of them, the practice nurses. If they are house bound then the district nurse will take care of them. The health visitor is somebody who can vacillate between the two really and ends up being used by the patients and by us to step in where there seems to be somebody fallen through the net." (Practice Nurse)

Senior managers were less sure that there was no overlap of roles. The view of the FHSA respondent was that there were areas of potential confusion, and a senior nurse manager reported that in his area district nurses were providing care in some GPs' surgeries that in most were being undertaken by the practice nurse. Specifically mentioned were immunisations, ear syringing and the running of chronic disease management clinics.

Communication between professional nurses was enhanced by the fact that many health visitors had physically moved offices to be based within the GP surgeries. This enabled regular contact to be maintained with colleagues. All the respondents clearly expressed their scope of practice, and referred patients to each other as seen appropriate:

"And we had quite a few meetings over several months just defining who did what and looked at every aspect of care like diabetes, what involvement everybody had and in some cases there was a bit of overlap but tended not to be, I mean, we see the practice nurses at this practice tend to have there own speciality so one is the main person for family planning and smears and that kind of thing; one deals with all the asthma, one deals with diabetes. They've both done diplomas in the relevant subjects and so you know who to turn to for expertise on those subjects. If you look at the health visitor I supposed mainly 0-5s, she's just taking up doing immunisations of all the babies as well which she hadn't done before, but also elderly visits." (District Nurse)

"I mean part of it's determined by the trust in that they decide in discharge planning who they feel the relevant person to do the visit. Yes, so I mean if it's

> an elderly person particularly doesn't appear to have any nursing needs but lives alone, maybe is a bit at risk, they just feel perhaps might have housing problems or something like that ... they tend to be referred to the health visitor. But if they feel that they might have a pressure sore or a dressing or anything like that... when it comes to incontinence there tends to be an overlap and the health visitor and I actually pass things backwards and forwards across the desk to each other saying do you know this person, are you going to do the assessment." (District Nurse)

It appears that any confusion in who does what in the community nursing team lies with the GP. As commented upon by the GP respondents this confusion could be compounded by the restriction on practice imposed by trust employers limiting the scope of practice for those nurses employed by the community trusts. It was generally the GP who had difficulty in making appropriate referrals to the nursing team:

> "GPs seem a bit confused with things like wheelchairs and walking sticks and whatever and in fact have been known to write messages to us both, one to deal with wheelchairs and one to deal with incontinence. In times gone by we would have probably both visited that patient to assess and find the other one had actually been in whereas now we say to each other do you know them and they'll say I've had a referral as well, so you both get a message and we also got a message, we both had a message written in about the same patient, are they getting support for the carer and I mean, obviously it doesn't need both of us to go and so the nurses decide." (Practice Nurse)

Working initiatives between the primary health care nurses e.g. menopause clinics, adolescent clinics, formed part of successful collaborative working relationships between practice nurses and trust employed nurses, utilising the unique skills of the various professional groups.

6.0 *Key Issues*

6.1 GPs are becoming increasingly influential in defining the roles of community nurses and the establishment of appropriate levels of qualification and skill.

6.2 The GPs interviewed were largely supportive of practice nurses extending their responsibilities to include the diagnosis and treatment of minor ailments. Many of those interviewed were operating within locally agreed protocols.

6.3 Given the move towards the employment of D and E grade nurses in the community, there is a lack of clarity as to whether the responsibility for initial client assessment should continue to remain with the G grade district nurse, or whether diplomates are "competent to assess the need for care ... in a range of institutional and non institutional settings" (UKCC, 1986 p 40). Research is urgently needed in this area.

6.4 There was evidence that managers were beginning to question whether, given the increased depth of pre-registration education, a specialist qualification was a pre-requisite for working in community settings.

6.5 The district nurses confirmed that their traditional role is changing from that of care giver to the chronic sick and infirm to that of caring for more acutely ill patients and acting as care co-ordinator.

6.6 The educational role of the district nurse in relation to the management of acutely ill patients at home was also emphasised by many respondents.

6.7 The role of the health visitor is assuming distinct forms in different parts of the country in response to the requirements of the respective Health Authorities, with some being restricted to child health and public health work, at the expense of a 'cradle to grave' service.

6.8 HVs were under pressure from commissioners and GP fundholders to produce measurable outcome data to demonstrate efficiency and effectiveness.

6.9 The ongoing, politically sensitive, discussions concerning the responsibilities of health agencies to those with continuing care (as opposed to treatment) needs will be reflected in the client profile of the district nurse.

During the inductive phase of the study, all nurse manager and nurse practitioner respondents were invited to discuss the role of the nurse in the multidisciplinary team. In addition, in the spring of 1995, the researchers conducted six multidisciplinary focus groups, two in each region, with a membership drawn from acute and mental health services respectively. It should be noted that the primary health care team was separately examined in Chapter 6.

It became evident that the concept of the multidisciplinary team (MDT) is a broad one, wide variations in definition and cohesiveness being reported both within and between specialities. In the field of mental health, where formal interdisciplinary meetings were more common, the composition of teams varied from area to area and between hospital and community. This finding is supported by Peck (1995) who observed:

> "...it is misleading to assume that all teams providing services for adults share common characteristics. Central policy makers have never defined their core functions, nor have they specified that they are an essential component of community mental health services." (p28)

Within the definition of a "team," the MDT has significant disadvantages. Each member is required to operate within their own statutory framework, responsible to different professional managers and working within different cultures and organisations. Moreover many teams are not co-located and have no identified leader - even for operational purposes.

The Multidisciplinary Team in Mental Health

Managers and practitioners from the field of mental health services indicated earlier in the study that there was a high degree of maturity in multidisciplinary working in this area, when compared to other sectors of health care provision, and this was largely upheld by the findings of the MDT focus groups. However, ironically, it was precisely because the concept in this area was better defined that it proved difficult to recruit to the focus group. A number of professionals who contribute to care declined to attend a group giving as a reason the fact that they did not consider themselves to be members of the multidisciplinary team. Both in telephone discussions with those who declined the invitation and from the data collected in the focus groups, there was agreement that the usual composition of a hospital based mental health multidisciplinary team consisted of a consultant psychiatrist and accompanying junior medical staff; a ward manager and nursing staff; a social worker, an occupational therapist and (sometimes) a psychologist. A pharmacist and a dietician who agreed to participate in one group confirmed that they worked "on the fringes of involvement, really". So peripheral do

these professionals perceive their roles to be that their counterparts could not be enticed to join either of the other two groups.

Despite the relatively tight definition of team membership in mental health, there was nevertheless a recognition that the members did not have a full and clear appreciation of one another's roles. This was said to lead to inappropriate referrals and client allocations, and to differences of opinion as to the best person to tackle an issue. For some respondents, this constituted a problem:

> "I've noticed that in our allocation meetings, if nurses are trying to refer to social workers and social workers are saying "well, that's not my job, you can do that" and "it's not necessary" and..., so there's a bit of a confusion really, something needs clarifying." (Occupational Therapist)

> "I think in our team, there's a bit of ... I notice there's ... there is a lack of understanding of what everybody's role is." (Consultant Psychiatrist)

> "I can't claim to know everything that they do, and they certainly don't know everything that I do and this is made by a ... lot of nursing colleagues in the team ... This is obvious by some of the comments that are made." (Social Worker)

However, it was suggested by one senior house officer that the lack of clarity of roles within community psychiatric teams was not necessarily a negative feature. Another respondent, a consultant psychiatrist, remarked that increasing flexibility of roles was in the interest of holistic care and that, within the context of the current care environment, role boundaries should be loosened rather than firmed up:

> "And actually with the introduction of the CPA, with the key worker role concept again, that's actually encouraging one person to take on a broad overview, like a care management view really, or the complete care of somebody as well, so there's a push actually from above." (Occupational Therapist)

It was frequently pointed out that, within the team, decisions concerning the allocation of key workers are frequently made without reference to the professional status of the team member. Key drivers are the nature of the relationship between the client and the individual members of the team, and considerations of expertise in the specific therapeutic input or approach required. Thus for example, whilst a social worker will be allocated to carry out a social assessment, or a nurse when intra-muscular medication is a feature of treatment; in relation to shared skills:

> "Really it is the most appropriate person at any given time who would actually undertake those particular components of care." (Senior Manager)

A middle manager in a mental health trust commented:

> "You may well have a sort of quite junior nurse who is working within the team who is ... much more qualified in Transactional Analysis or Gestalt ... then it is probably likely that they're actually more qualified or more confident than the consultant with twenty years experience." (Middle Manager)

In this scenario, it was argued by some respondents that the fluid, imprecise nature of the nurses role was a positive advantage rather than the liability it sometimes appears to be. Nurses, by virtue of history and practice, it was argued, are the quintessential generic workers:

> "... actually having a team of resources there without the specific identified roles ie if it's a finance matter then it must be a social worker who deals with it; if the person identifies that they're not being able to cook then an occupational therapist must deal with it, and I don't see that as particularly positive. So I am in two minds really with it, whether the nurse being quite generic is actually quite a strength or a weakness I'm not really sure." (Ward Sister)

Genericism was very much in the air. Those who applauded the flexibility of the nursing input also recognised the increasingly flexible nature of the input of other professionals:

> "I think what's happened, or certainly to my knowledge what has happened, is that other professions who weren't directly involved in care as such, and used to actually be more involved as an outside resource that used to come in and out of somebody's care, that's now changed. ... For example an Occupational Therapist who is a key worker can still become slightly generic and has to take on a much more co-ordinating role." (Middle Manager)

That the care programme approach has the propensity to make individual professionals nervous was evident from the responses of many staff. The following quotation sums up one social worker's aspiration for the future:

> "I suppose there's a little bit of anxiety tinged with apprehension ... I think if we can get over what in the past has seemed like mistrust, not of each other as colleagues, but of plans which have been formulated... without those at ground level really being involved then I think we will probably all be pulling in the same direction. If everyone knows what the other people are doing and what expectations are. If it's clear, above-board, readily identifiable, then I think there is hope that we can work together." (Social Worker)

In a client centred world the overwhelming view from the mental health team was that patient's needs and interpersonal preferences are no respecter of professional qualifications.

Currently, it was noted that attempts by some community mental health team leaders to establish cohesive teams operating to locally agreed allocation criteria were being thwarted by the actions of some GPs who decline to comply with referral systems to the team:

> "I think in terms of the one team that I work for, the CPNs in particular encourage GPs to refer direct to them which is against the purchasers requiring everything to go through the team really." (Occupational Therapist)

> "There's also a problem with doctors wanting to refer to CPNs and wanting to speak to a CPN, whereas, like, social workers will say "No, we're a team. You speak to me", you know, "and then we'll assess who's the most appropriate professional." (Occupational Therapist)

One reason for these referral patterns, it was suggested, was the fast response which CPNs were required to make under the terms of the 1995 Patient's Charter. Another was that GP's simply had more clarity about the competencies of the CPN than those of the social worker or occupational therapist. The introduction of patient banding categories was felt to be a useful means of ensuring that the specialist expertise of mental health professionals was being appropriately used.

The Multidisciplinary Team in Adult Services

In the acute trusts, a wide range of professionals joined the groups to discuss the concept of team working. It was evident from the discussion that the range of experiences of inter-professional working was broad, varying from excellent to non-existent. Examples of good practice were cited in speciality areas - care of the elderly, rheumatology and neurology were all given as examples. In the area of general medicine and surgery, however, the respondents interviewed reported that there were no meetings of a multidisciplinary nature, and that there was a general lack of understanding of the roles of various professionals involved in the care and treatment of patients:

> "I don't think there's many people round this table actually knows what the person next to them does." (Senior House Officer)

> "I think even in a hospital that ... that you still get ... the confusion and ... you still get teams that don't actually work necessarily together on a daily basis." (Speech and Language Therapist)

Apart from the well defined areas of good practice mentioned, the picture emerged of a multitude of professionals entering a ward (where they may not even be known) carrying out an assessment, making therapeutic interventions, reporting the outcome to the nursing staff and leaving. There was no occasion for all concerned with the care of patients to sit down together and attempt to piece together a complete picture. Whilst no-one believed this lack of formal communication to be in the patient's best interest, it was believed that such was the pace of life on busy medical and surgical wards, that sitting down to discuss a patient was a luxury that no-one could afford. The MDT respondents typically covered several wards and were under pressure to treat all the in-patients referred to them. One expressed a feeling of being trapped into traditional patterns of behaviour by traditional patterns of funding. He could not envisage, in the present climate of performance indicators, being able to successfully argue a case in which he treated fewer patients to a higher quality:

> "Yes it would be great to have case conferences, have discussions with other staff about particular treatments and it would lead to improved quality of treatment. But because it doesn't happen now it would have to go through the whole process because, if it does happen and a member of staff even spends twenty minutes discussing with other professionals about the treatments, that's another patient's treatment that's not been carried out. So it would actually seem to have quite an implication on the way we cost services which

have always been costed on an historical basis. And the general drive is towards cheaper, not necessarily better." (Radiographer)

Respondents made repeated reference to the observation that nurses on acute non-specialist wards were "constantly firefighting". Such was the turnover of staff and of beds that careful planning of discharge was seldom possible:

> "The general wards are the ones that are the poor relatives, if you like ... they don't have that sort of togetherness." (Social Worker)

> "It's the fast throughput on the acute medical wards which can often cause problems." (Occupational Therapist)

> "If you're in a general medical ward and you're fire-fighting constantly, you're just taking one hit after another, you've got no time to build a team rapport ... you've got no time to arrange a meeting. So although you might have the good ideas then if you've not got the time and the facilities to actually do it then you fall flat on your face." (Radiographer)

Professional visitors to such wards recorded that their dealings were almost exclusively with the resident medical and nursing staff:

> "Pharmacists go out onto the wards now and get involved with patients and medical staff and nursing staff. They don't tend to get involved ... with other disciplines very much and I think that's probably one of our failings." (Pharmacist)

> "There's not actually many wards, really, are there, that are actually geared up to ... to everybody working together or for the same purpose." (Social Worker)

The situation is even worse when professionals tend not to visit wards, but operate out of a department, to which patients travel from the wards:

> "We're very ... very isolated in lots of ways. We work within a team within our own department but not as any ... part of any other team." (Podiatrist)

Context and Power in Multidisciplinary Team Relationships

Several respondents from both acute and mental health services commented that it was still the norm for the leadership of team, where it meets regularly, to rest with the consultant who chairs it and directs its business. This despite the view of Spratley & Pietroni (1994) who claim that doctors are trained and socialised into a system that requires them to make difficult decisions autonomously and without consultation with others - a perspective antithetical to that of the multi-disciplinary team. A middle manager in forensic services offered an explanation for this phenomenon:

> "Probably because a lot of years ago they were called Doctors' Ward Rounds and even though the title's changed to Clinical Review Meetings or something like that it's just continued ... the multidisciplinary team meeting is a direct descendant of the ward round." (Middle Manager)

A senior house officer in an acute trust remarked:

> "It depends on the consultant very much. I mean, a lot of the younger ones ... are much more ... willing to involve with the people in the management of their patients." (Senior House Officer)

"I think ... a lot of it's due to the attitude of ... the medical staff as well. Even though they're not supposed to be the centre of it, if they insist on having it and ... sit and listen to people then it's more likely to continue on and people get a better deal." (Senior House Officer)

"Everything has to go by the psychiatrist really and then he will direct the work, so it's patchy." (Senior House Officer)

Whilst nurses were certainly not seen as natural leaders of the MDT, the view expressed consistently by nurses and their managers that they occupied a *central* position in the multidisciplinary team was strongly upheld by hospital based members of the MDT in both acute and mental health settings:

"It tends to be the nursing staff who are central to the multi-disciplinary team because they are there in the in-patient setting, they are there ... 24 hours a day, whereas the rest of us might drift in and out." (Physiotherapist)

"I think the doctors like to think that they do it, certainly the consultants like to think they're the co-ordinators, but in fact it's usually the nursing sisters and the staff nurses." (Senior House Officer)

"We perhaps depend on a nurse to give us clear information about what another member of the, quotes, team is doing." (Social Worker)

"I certainly think the nurse is the link between everybody else and the team, because they're the ones who are there with the patient all the time ... giving the hands-on advice." (Dietician)

"The nurse spends far more time with the patient than the physio or the doctor or the (occupational therapist) or the dietician .If you were to remove the nurse the patient just wouldn't carry on, do you know what I mean. I can't see how the patient could be cared by all the little bits."
(Senior Nurse Manger)

"I think sometimes on a ward the nurse plays that central, sort of, co-ordinating role, it's not a lead role, but it's just ... you know, has everybody been in contact with everybody." (Senior House Officer)

In contrast, care in the community for the physically sick is seen as a fragmented activity, with a large number of professionals visiting patients, frequently unaware of how many others are also engaged in treatment. The multidisciplinary team do not view the nurse as the obvious co-ordinator in this setting. With the loss of the twenty four hour nursing presence (if not of the twenty-four hour responsibility) respondents reported that the patient assumes the central role as the only person who has an holistic view of the care being given:

"For example, people with motor-neurone disease and there can be fourteen different people going into that person's house ... (all) part of a multi-disciplinary team. The only person who knows everybody is the patients themselves."

"I think it's from social services though that it's coming in the community, that they're recognising that there is usually a co-ordinator. But it isn't necessarily a nurse"

However, if for no other reason than sheer weight of numbers, nurses are reckoned to be a formidable group at the moment, although it was pointed out by two senior managers that there was no room for complacency. Quite simply, in answer to the question "what would be the effect of removing the nurse from the multidisciplinary care team," the answer from a majority of respondents was that care services would 'fall apart,' because the nursing service provided the infrastructure within which treatment and care were delivered. A consultant psychiatrist explained her reaction:

> "Oh, God, what an awful thought ... if something's going really wrong the nursing staff will get in there and do something that's helpful! ... if someone is going berserk and needed some work it would be the nursing staff that would do something because most of them have come through training in general psychiatric wards." (Consultant Psychiatrist)

The Nurse as Jack (and Jill?) of all Trades ...

Both managers and nurse practitioners had earlier remarked on the expectation that nurses would cover for other professionals in their absence, whether continuously (as in the case of community hospitals, where no specialist services were offered) or, in district hospitals, at evenings and weekends. In relation to physiotherapy and occupational therapy nurses described the potential for sharing of roles:

> "The physiotherapists come in and do pre-operative breathing exercises and walking exercises and things like that, occupational therapists do dressing practice but come the weekend who does this, who carries this on, it is the nurse." (Ward Manager)

Gijbels' (1995) study of mental health nurses reveals the effect of these assumptions on the professional definition and self esteem of nurses:

> "A picture of the nurse as a generalist emerged, assisting others, mopping up, without a clear identity of what it is they should be doing themselves." (p263)

Practitioners speaking within the focus groups confirmed this view. They identified their roles as "plugging the gap" when other professionals were unwilling or unavailable. Three participants in an acute trust contributed the following views:

> "... all the things nobody wants to do, the nurse does." (Practitioner)

> "I think it is again a matter of not only the human element, but the professional element in that they see some of them as being superior and again this boils down to the fact that we pick up what everybody else doesn't want." (Practitioner)

> "During the week we value the physiotherapist and the occupational therapist, but come Saturday and Sunday we do the job instead." (Practitioner)

This 'sweeping up' role of the nurse was acknowledged by the various members of the multidisciplinary team. However, there was expressed a view that the nurses lacked the knowledge and expertise to perform this role, and thus patients received an inferior, even useless service:

> "Isn't there a difference here between participation in the treatment and just the simple carrying out of the instructions. I mean, if the nurse were to adopt the traditional role, you would go in as the expert on dietary requirements and

you would give your... treatment or your recommendation of treatment and... and in the old days the nursing staff would just sort of carry it out to the letter." (Audiologist)

"A lot of the things which the nursing staff do say to the patients contradicts what we've already told the patients who are not getting the same message across, so certainly there is inadequate training... and I'd much rather them be trained before they said anything a lot of the time because it does create a lot of confusion. " (Dietician)

"Being ears and eyes, on our behalf is absolutely great, but the ears and eyes have to know what they're looking for and what they're listening for. We've learnt through painful experience, I'm sorry to say, that where nurses have conducted hearing tests, for example, the safest and best thing to do in the first instance is throw the result in the bin on the basis that it would appear that... what they have been doing has been a wholly one-sided thing without proper training." (Audiologist)

Again, the situation was better in specialist areas where nurses were recognised to have gained further training and were better equipped to participate in specialist aspects of care. An example cited was that of a diabetic nurse who had completed an ENB post registration course, and therefore met the standards of knowledge required by the dietician. Overall, however, this respondent believed that nutritional knowledge was poor amongst nurses. However, some sense of proportion prevailed. The audiologist quoted above, who had been scathing of nurses' abilities in his field, looked around the room at his eleven fellow participants from other professions allied to medicine and remarked ruminatively:

"... it would take somebody fairly superhuman to be able to cope with their general training that qualified them for specialisation in all the areas and it would just be too great a role, I'd have thought." (Audiologist)

Nevertheless, if the view of the professionals cited above (and the numbers involved in the focus groups mean that these findings should be treated with extreme caution) is that nurses are not adequately equipped to provide maintenance therapy over evenings and weekends, then consideration should be given to the possibility of enhancing opportunities for these professionals to participate in curriculum development and delivery of nursing courses. If further exploration of this issue reveals that the problem is significant, and that learning needs cannot be comfortably addressed within existing courses then nurses need to consider their position in relation to the code of conduct, and managers must consider other strategies for the provision of these services.

Perceptions of the Nurse within the Multidisciplinary Team

Respondents stressed that nurses would in the future have to develop more confidence in their role within the multidisciplinary team and in their unique contribution to patient care. It was generally agreed that nurses tended to be insufficiently assertive, deferring to the opinions of consultants and some other

professionals, such as psychologists. In order to accomplish this, nurse managers expressed the view that they had to become increasingly involved in treatment decisions, instead of assuming the role of provider of background information informing the decisions of others. Gijbels (1995) reflects the situation within mental health precisely:

> "Nurses informed other professionals about patient behaviours; these other disciplines then designed treatment for nurses to implement." (p463)

This issue was particularly acute in mental health where it was argued in the context of nurses assuming a more explicitly therapeutic role, (see Chapter 4) and taking a proactive rather than reactive view of patient and client treatment regimes. A middle manager responsible for mental health services stated:

> "One of the great challenges I faced when I first came to the unit, was to try and get over this almost institutional role that the nurses had in the ward round of that ward. Nurses just spoke about what the patient was doing - a reactive ... sort of discussion." (Middle Manager)

Nurse managers interviewed in the study claimed that nurses were the least influential members of the multi-disciplinary team. This perception was supported by the statements from nurses who participated in the focus groups.

> "I think one of the biggest things for me is that psychiatric nurses must start to realise perhaps that they are the equal of other people in the multi-professional team and perhaps the other members of the multi-professional team need to realise that as well, that it isn't this god-like figure of the doctor still and then underneath that the psychologist or the social worker with the nurse right at the bottom." (Middle Manager, Forensic Psychiatry)

A number of reasons were suggested for this phenomenon and are explored below. One explanation lay at the "nature" end of the spectrum:

> "I think ... it's partly due to why people come into nursing in the first place ... which is essentially to care for people, and those kind of attributes don't lend themselves to people, standing up in the middle and saying 'deal with this for this person'." (Middle Manager, Mental Health)

The issue of gender in power relationships was raised by some respondents; the implication being that nursing had suffered from the predominance of females within its ranks. A practitioner speaking in the adult focus groups commented:

> "I see it very much tied up with sexism. I have worked in psychiatry where you have a tradition of male nurses as well as general where you have a basically female model. We all know psychi nurses are stroppy bastards, but that is basically because you had a predominantly male profession." (Practitioner)

Salvage (1992) would agree. In support of this view educationalists quoted the numbers of male students in student representative positions which far exceeded their proportionate percentages in the total student population. Ultimately, however, this explanation does not address how physiotherapists and occupational therapists,

who also have high numbers of women in their ranks, should fare so much better. As Mc Kee and Lessof (1992) observe:

> "The therapists have made it abundantly clear that they are autonomous professionals and are not subordinate to doctors." (p 61)

One respondent, also a middle manager in mental health, ascribed the passivity of the nurse to the nature of the traditional relationship between doctor and nurse, as leader (prescriber) and follower (administrator). An educationalist claimed that this ascribed passivity was an outcome of the process of socialisation into the nursing profession (see Melia, 1987). Other respondents claimed that nurses are socialised to respect the 'pecking order' which is reported to be 'as strong as ever.' A teacher describes a discussion with student nurses:

> "I was talking about skills mix and I said ... I don't know about now but in my day, it wouldn't matter what skills you could have you know a battery of letters after your name as long as your arm; but if you were the last person to arrive at the ward you were at the bottom of the off-duty and you didn't get to make any of the decisions. And the person at the top, regardless of what they were, got to make the decisions. And they said yes it's still like that, I'm talking about twenty years ago and it hasn't changed." (Education Manager)

> "You see it is so easy to learn to become intimidated." (Educator)

In the study referred to above, Salvage lends support to this view of subjugation, arguing that qualified nurses, even now, see their role as that of an assistant and supporter of the doctor to whom loyalty and obedience, is due:

> "The price paid for membership was subordination. Despite what they were taught in the classroom student nurses arriving in the wards were immediately presented with an image of themselves as subordinate members of a subordinate division of the health team." (p19)

This quotation leads nicely into another point made by one respondent who suggested that a contributory factor to this perceived low status of nurses was that alone amongst the professions, nurses join the multidisciplinary team as very junior students, and therefore establish relationships with other professionals from a position of weakness.

Another reason postulated was the fact that the twenty-four hour nature of nursing, so important to its definition, means that the ability to work as a member of a team is vital to the successful nurse. It was suggested that this trait might be antithetical to assertive leadership:

> "Nursing, by it's nature isn't about autonomous practitioners ... that is cultural as well, there's not necessarily any reason for that, there's no reason that nurses shouldn't act as individuals ... it's just easier for organisations that they do work as teams ... if you think about it, if people are working as individuals, they probably need more of them." (Middle Manager, Mental Health)

Related to this is the observation that, whilst all the other members of the multidisciplinary team are named individuals, within hospital wards nurses are a group

who are represented on the multidisciplinary team. This leads to a certain amount of stereotyping of the, "nurses won't like that ..." type. An occupational therapist remarked:

> "But if it's a nurse working with a patient then it can be up to three or four different people, certainly with the team approach occurring these days. And it only takes one of them not to pass the information on then things break down." (Occupational Therapist)

Finally, it was asserted that the training process has not in the past equipped nurses to deal with conflict. Conflict arises within the multi-disciplinary team when all members of the team are working under pressure, each trying to achieve quality outcomes with limited resources. Nurses it seems are often "left in the middle of these negotiations". Despite the described centrality of the role of the nurse in the multi-disciplinary team, respondents reported that nurses remain unhappy about some of the outcomes of the negotiations within the team. Nurses do not, it was claimed, recognise the potential for power in this relationship:

> "It goes with the job ... it just goes with the job sometimes it's not very pleasant and sometimes you can achieve a lot, and I think well I hope that I personally got on quite well with all the multi-disciplinary team, enough to have a good working relationship. I'm sure most nurses try and achieve that but inevitably there's always a personality clash and I think that's why it very often falls to the ward sister to sort it out rather than it being sorted out on a one-to-one basis". (Practitioner)

> "I think it falls fairly heavily on the nurse because a nurse tends to be in the middle very often and you've got sort of the nurse there and you've got relatives, patients, other staff - domestic staff, portering staff, medical staff, physios and you're stuck in the middle of everybody." (Practitioner)

It was suggested that the position of the nurse in the multi-disciplinary team is almost unenviable and that the ability to function at multiple interfaces requires great flexibility and skill.

A positive suggestion made by one senior manager to improve the ability of the nurse to function within the multidisciplinary team concerned the use of appropriate and contemporary business language. She expressed the view that nurses should 'articulate and use language as do others in a certain forum,' and went on to predict that it would become increasingly important for nurses to articulate their views and resource requirements in this fashion:

> "I think whether in hospital or whether in the community, everything's being run on very much business lines and we have to articulate our needs in a more business like way. ... I don't think that at ward manager level that they've always had that appropriate skills and training" (Senior Manager)

The Way Forward

Central to this is the tenet that all who contribute to patient care should understand the professional expertise and particular interests of the others. Many of the

respondents within the multidisciplinary focus groups gave testimony to the fact that whilst they were not in a position to define the role of each and every fellow professional, at local level good and effective working arrangements were in place. It was recognised by respondents that education could enhance this understanding:

> "It's a lovely idea to have... multi-disciplinary training, it doesn't often happen. we're probably again quite fortunate in that we do have the odd meeting where we do ... get together and have some training, but it ... it is very rare and few and far between." (Physiotherapist)

> "One of the best things I've found about actually going on courses, you know, ... like this. You actually understand the problems of other people and find they're actually not that much different from yourself." (Senior House Officer)

However, it was suggested (and this echoes the point made in Chapter 6) that there was no real substitute for physical proximity - working together in shared offices on a daily basis. In this environment, informal communications are facilitated and a thorough understanding of working practices and responsibilities can be gained:

> "There are a lot of educative benefits to be gained by actually working together rather than just having representatives coming up, you know, to sit at the duty desk, or for us to meet for allocation meetings." (Social Worker)

Collaboration in joint record keeping is also advocated in the future as a means of meeting agreed care objectives and sharing of information in the patient care episode. Teams, particularly mental health, believed that there was a need to settle down into new working relationships with GPs, and that a major step into the future would be taken when referrals came into the team rather than to one specified member of it:

> "I think there is certainly the idea that referrals that come through are going to be less focused on either CPNs or social work. I think there is ... there is hopes that there will be just referrals to the multi-disciplinary team." (Social Worker)

In this way, the team would have an opportunity to further clarify the roles and expertise of each of its members - a vital development which would improve the quality of client care after discharge.

7.0 *Key Issues*

7.1 Despite the relatively tight definition of team membership in mental health, there was a recognition that the members did not have a full and clear appreciation of one another's roles. This was said to lead to inappropriate referrals and client allocations, and to differences of opinion as to the best person to tackle an issue.

7.2 The Care Programme Approach requires key workers to have an holistic appreciation of the needs of clients and a comprehensive understanding of the range of services and agencies who may contribute to these ends. Nurses believe that they are quintessentially generic workers.

7.3 Nurses were perceived, by nursing managers and other members of the multidisciplinary team as low profile members, engaging reactively rather than proactively in discussions relating to client treatment and care and lacking in confidence in their dealings with other members.

7.4 There is a widespread expectation that nurses will carry out certain therapeutic procedures when other professionals are unavailable. If this is explicitly accepted as a legitimate part of the role of the nurse, there are indications that nurses need a firmer knowledge base to perform effectively, and contributing professionals should be involved in curriculum development and delivery.

The future direction for Nursing, Midwifery and Health Visiting education was most recently set out in the "Statement of Strategic Intent" (DoH 1994f). This statement recognised that the achievement of the vision of the profession presented by such reports as "New World, New Opportunities" (NHSME 1993b), "The Report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting" (DoH, 1993a) and "Working in Partnership" (DoH, 1994a) will depend on the continued preparation of nurses, midwives and health visitors who are fit for practice. The report defines the fundamental principles which must underpin Nursing, Midwifery and Health Visiting education as:

- Patient Focused
- Practice Led
- Student Centred
- Equitable
- Appropriate
- Effective
- Responsive
- Collaborative
- Accountable "

(DoH, 1994a; p 5)

In particular, the Nursing, Midwifery and Health Visiting Education forum acknowledged the findings of the published report of the "Heathrow Debate" - The Challenges for Nursing and Midwifery in the 21st Century (DoH 1994c) and sought to give momentum to educational initiatives aimed at improving the quality, relevance and cost effectiveness of education programmes.

Turning specifically to pre-registration education, the NFER review of the Implementation of Project 2000 commissioned by the Department of Health (Jowett et al, 1994) was cautiously optimistic of the effects of implementation, both from the point of view of the students who had completed the course, and of the teachers and practitioners who felt that their own professional development had been enhanced by its introduction. This is broadly supported by the findings recorded below. Some of the notes of concern sounded in the NFER study, however, also find their echo in the pages that follow.

The Relationship between Service and Education

For many trust staff within the study, there were issues of regret in the formation of large colleges of nursing, managed independently of trusts. Prior to the amalgamations senior managers responsible for education had worked side by side with their counterparts engaged in service delivery with the result that educational objectives were fully in alignment with those of service. The current arrangements had given rise

to a number of challenges. As enlarged colleges began to relate to ever greater numbers of trusts, a number of complications were introduced. Inevitably, the often competing requirements of the trusts had to be balanced. Then too, senior staff found themselves located in offices physically remote from service colleagues in certain of the trusts that they served. Concomitantly, given the competitive market in which trusts were developing their agenda, and the fact that at least some aspects of business planning are considered to be 'commercial in confidence,' inclusion of educationalists in key strategic meetings is by no means automatic. Furthermore, at all levels, both colleges and trusts in the study were engaged in an almost continuous review of their structures resulting in a need for constant vigilance in defining appropriate lines of communication. Notwithstanding the tributes paid to the degree of effort invested in maintaining good communication links, there were reported to be increasing difficulties at an operational level, particularly in relation to the day to day information about service areas used for student placements:

> "... we normally had a fairly close relationship with the managers here, and were able to get a very rapid response in terms of when it came to placing students. Which areas were suitable, which areas were not, staff holidays, staff sicknesses, the levels of disturbance on the wards, male cover, this sort of business, so we could get an overall picture of what the unit was like, and where would be suitable for particular students. Did we need to send male students to certain wards? Did we need to avoid sending a student who was pregnant for instance to a particular area? At the moment it's not entirely clear how we're going to get that kind of information, how we're going to liaise."
>
> (Educator, Mental Health)

> "We had a fairly close relationship with the senior nurse managers previously, they were involved in our planning, too, so if there were changes impending within the service sector, we would know about that, and it would feed into our planning and our curriculum, that as I say is in abeyance at the moment, we don't know how things will continue, so it's quite possible for instance for the skill mix to alter here, and we not know about it, until it's a *fait accompli*. We then discover that for instance that the levels of supervision may not be adequate from point of view of the ENB and have to take steps, literally a week or so, before the event is to occur. That can make things difficult."
>
> (Educator, Mental Health)

The views expressed regarding the importance of such liaison supported the findings of the ACE report (ENB 1994) which states:

> "... there is a need, highlighted by the research, to maintain regular liaison between educators acting in link roles and practice placement areas. Where, there is good liaison, problems of continuity of support are more easily sorted out ... The liaison role is thus essential in ensuring that preparatory mechanisms are in place." (p 45)

The introduction of Project 2000 had represented a major upheaval for the trusts, who, as Jowett et al (1994) reported, had experienced difficulties in reconciling the logistical demands of replacing students with fewer (but allegedly more efficient) qualified and unqualified staff. The concurrent implementation of the NHS reforms which led to trust budgets being top-sliced for the purpose of funding educational provision further

changed the nature of the relationship between trust and service providers and in some areas created tensions. Traditional informal sharing of resources and staff became the subject of formal service level agreements, contracts and quality monitoring mechanisms. Respondents cited examples of specialist staff who had previously been happy to contribute their expertise to pre- and post-registration courses whose time now had to be costed and whose input therefore became a target for savings within cost improvement programmes.

For the educationalists interviewed, a key issue for debate was the proposed integration into higher education. Only one college knew from the commencement of the study the identity of the HE institution with which it would integrate. This partner was not the university with whom the college had a long-standing memorandum of co-operation. Another college, within six months of the start of the study had its management accountability transferred from its health authority to a local trust when the bidding process in respect of HE integration failed to identify a suitable partner. The third, having recently changed its University affiliation links, faced the possible prospect (not eventually realised) of integrating with its third partner in the space of a year. The integration process was time consuming and, for some, anxiety provoking. The end point of full integration was also an issue of some concern for trust managers interviewed, who were concerned that ultimately the college might decamp to a University campus and that in any case inevitably the NHS agenda would be diluted by that of higher education.

The publication of the Department of Health letter EL 95/27 setting out the proposals for the establishment of commissioning consortia, post dated the interviews and thus we can offer no informed view as to how these proposals might further alter the relationship between service and education providers. We may, however, speculate that it might.

Project 2000

There was universal recognition of the value of the academic professional base addressed within the diploma programmes which was both welcomed and applauded by the service managers taking part in this study. Community managers expressed a hope that the diplomates of the future would seek careers in community nursing as a direct result of the increased opportunities to offer care in home settings within the pre-registration programme. Indeed there was evidence that newly qualified nurses from diploma courses were being employed as D grade staff nurses within community teams. Amongst educationalists there was general enthusiasm for the new opportunities offered by the diploma programme, although this was tempered with some concern about group size, the amount of practical experience available, the quality of supervision and the development of skills. All of these are explored below.

The positive aspects accentuated centred around a more holistic view of client needs, greater exposure to the community, and simply more time devoted to the acquisition of knowledge:

> "I've always thought that one of the benefits of Project 2000 Common Foundation Programme was exposing people much more to a range of factors contributing to people's health or well being or illness."
> (Educator, Mental Health)

> "I think also being able to function in both hospital and community ... Project 2000 has addressed that to some extent." (Educator, Adult)

> "That's what I mean when I talk about academic uplift, I mean an increased amount of knowledge which feeds into that process about making accurate judgements about what you see." (Educator, Mental Health)

There were positive comments too from practitioners. A senior practitioner highlights the importance of values set in nursing:

> "The way nurse training has changed is better in fact. You give a lot of knowledge base first and teaching of values and discussing prejudices and things. I think that's ever so important, I know so many nurses, senior nurses as well who have prejudices across the board, where I find the new students a lot of the time have a better attitude." (Ward Manager, Adult)

There was broad recognition of the benefits to students and the profession of the changed educational emphasis given in Project 2000 programmes. It was reported that the optimum skill that diplomates possess is the ability to use and manipulate a knowledge base to meet client needs in a variety of settings and in a context of change. Many adult nursing respondents volunteered the view that the focus of nurse education should remain that of health promotion and illness prevention. The following quotes are from a range of practitioners and managers:

> "There is more emphasis now, looking at preventative health care. I would hope that that would continue, and I think that needs to be the main focus always, because the majority of health care occurs within a community setting. I think perhaps more emphasis can be placed on the other issues that effect peoples health ... and that is around deprivation and around the whole issue of social deprivation etc etc ... and that must continue, and that shouldn't just be a focus for health visitors, that should be a focus for nurse professionals." (Senior Manager, Community Services)

> "I think nurse training is going to be based more on the well person rather than the ill person. Even though the theoretical knowledge base is being concentrated on now they are going to be concentrating more on the well person. Health promotion rather than curing. That is my impression."
> (Ward Manager, Adult)

> "We're a very unhealthy population, what creates that, so there's a lot of the course stuff is of the socio-economic effects of looking at health maintenance, that the nurse is a health educator, would be a key core element of that, and so it's around the person as a healthy human being and I would try and keep it that way." (Educator)

Clinical Skills

The training process to which nurses were traditionally exposed placed great emphasis on the development of psychomotor skills. The legacy of this, the task orientated culture, remains a powerful source of socialisation and control and for some it continues to be the benchmark against which the performance of today's students is assessed. Practitioners and educators raised this from a variety of perspectives:

> "What people don't see at the minute is what those skills are, all they see is that nurses haven't got the psychomotor skills of the students of the past." (Senior Educator)

> "A sort of nightmare I have is that ... time spent gaining experience is reduced and I'm worrying about how we manage that...it will depend on the type of learning that takes place and given changes in skill mix, that has implications for supervision." (Educator, Mental Health)

> "So I think the skills development is actually something which we perhaps, we've got too woolly on." (Educator)

> "If the traditional way of educational training was that they sort of spent four weeks in school and three months on the wards, now it is the other way around, they spend three months in college and four weeks on the wards. So in one sense the education has been extended, the training has been diminished but I am not sure we teach them any more than we used to in fact I would suggest that we possibly teach them less." (Ward Manager, Adult)

> "... if you talk about actual clinical experience with them it is very much more limited in the training process now." (Ward Manager, Adult)

Specific concerns were expressed by service managers in mental health; most vociferously by four managers interviewed who had responsibilities in the area of forensic psychiatry. All are from different organisations:

> "I've got great fears that we're going to possibly start turning out an awful lot of nurses who can professionally stand against other professions but who on the more basic less tangible nursing interventions don't really have a clue ... if the nurses ... aren't confident to actually do the more basic down to earth common sense things, they're dealing with people who are extremely poorly etc then I don't know who's going to take that on." (Senior Manager, Mental Health)

> "Take for instance working with personality disorders, which is difficult anyway, ... people can sit down and tell you all the things that are involved, all the medical things that you need to know about working with personality disorder, ... but all of that goes out the window when you are actually confronted by somebody who is trying to manipulate them or whatever... they don't know much about how to manage somebody's case on a day to day basis ... they don't really know about how to manage themselves on an everyday basis ... They don't seem to have very much confidence in taking on that role of actually being ... if you like ... a nurse. I think that what, one of the things, they do have a better theoretical knowledge in some areas it seems but ... they've also lost something as well." (Middle Manager, Mental Health)

> "I suppose we see it more acutely here because of the degree of challenging behaviour that we're faced with, but it's quite amazing to see people faced with a problem and what they're seeing is ... they're trying to see beyond what they're faced with, and they're lost." (Middle Manager, Mental Health)

"Just before I came here I had some third year students who I was working with. They were due to sit finals and looking towards being qualified and this is the first time on our ward when they were giving out medication and couldn't pronounce the names of the medication. Most of them knew very little about medication and I would imagine as a newly qualified staff nurse, would be an expectation that you are a nurse, you might be getting on with something else, but you would be expected to administer medication by the time you were qualified but it is not the case." (Middle Manager, Mental Health)

The last point was raised within the NFER review (Jowett et al, 1994) where it was said:

"For one mental health supervisor the 'biggest problem' as regards the Branch placements was having students coming at a late stage, never having done a drugs round, and having little knowledge of the drugs they were administering. A student in her final unit, whom she was supervising at the time, had, she said, done her first drugs round on that placement." (p78)

Butterworth, too (DoH, 1994a) had raised the 'widespread' concern about the development of 'essential' skills during preparation for part 13 of the Register. In January 1995, the English National Board for Nursing Midwifery and Health Visiting published its response. This states that curriculum planners would be required to:

- ensure equity of both time and focus for each of the four branches of nursing within the common foundation programmes
- review their teaching strategies to ensure that those providing input into the Common Foundation Programme are able to help students to set their learning within a mental health context
- ensure that there is articulation between the Common Foundation Programme and the Mental Health Branch Programme and that the development of the skills of the mental health nurse commence at the outset of the programme." (ENB 1995 p 5)

From the respondent sample of educators emerged a view that some of the psychomotor skills should be demonstrated in the controlled environment of the skills laboratory. This was represented as a well equipped laboratory in which skills would be demonstrated, practised and assessed. It differs from the traditional practical room in that learning is more student centred. All respondents agree that there are limitations to such a mode of learning, but it was recognised that the pace of life in many clinical areas is not conducive to the facilitation of psychomotor skills in students who have not had opportunities to handle the equipment prior to the experience, and that the model of the facilitated skills laboratory was worth pursuing. "We do not learn clutch control on the High Street" (Lankshear 1993).

"We might have to move back cyclically to clinical laboratories perhaps for the initial teaching of some of the practical skills that general nurses need." (Educator, Adult)

"I think experiential learning can take place in the classroom ... using a dummy in order to learn resuscitation techniques ... how you deal with an aggressive patient, or a paranoid patient." (Educator, Mental Health)

"I think there is a place for allowing people to practise in a safe environment ... but I think the problem is that people will not become competent in those areas, so they will be able to do some practice and they will sort of feel more secure in going out ..." (Educator, Adult)

The responsibility of the student to ensure that they maximise the learning opportunities afforded by practical placements is described by a senior educator:

"Nurses who come out have to realise what skills they've got, what skills they need, what knowledge they need to be able to practise those skills to become competent. They would be able to know the implications of, or be able to know where they get the knowledge from so that they can go in and be flexible, and to be able to go in and say, right I don't know what to do, let me see what it is I need to know to pick that up to be able to do it."
(Senior Education Manager)

If skills laboratories are increasingly being seen as an appropriate response by educationalists to concerns about the effectiveness of skills, this is acknowledged to be only a partial solution. Educators and nurse managers alike are agreed that competence in practical skills is an increasingly important issue and that such skills are best learned in the real world of nursing. It was stressed that students have a responsibility to seek, create and utilise practice opportunities to the full. Senior practitioners in turn have a responsibility to support and give feedback to students in the practice of clinical skills. The importance of the experienced nurse as a role model in relation to new skills cannot be overstressed. Within the field of adult nursing, nurse managers contemplated the specific and necessary skills that they require of the newly qualified staff nurse of the future. As discussed in Chapter 4, the skills most commonly mentioned were:

- Venepuncture
- Intra-venous administration of drugs
- Insertion of peripheral Intra-venous cannula

Also raised by some managers were the following issues:

- Urinary catheterisation of men and women
- Treatment of anaphylaxis
- Interpretation of:
  - Electrocardiographs
  - Blood chemistry reports
- recording a 12 lead ECG

Managers asserted that the attainment of these skills would enhance the ability of the nurse to provide holistic nursing care and improve the quality of the patient experience. A senior ward manager described these skills as essential. She stated that educationalists must be aware of how nursing is changing and should be prepared to incorporate these skills into pre-registration curricula:

"These extra skills that we are now having to learn are not the skills that I needed when I qualified ... I think it's just the extra skills that are not extra any more, they are now necessary skills. It depends where you work, where you choose to work, but I think anyone who works in acute areas, these skills are not extra, it's part of your daily routine." (Ward Manager, Acute)

The call for the inclusion of these skills within pre and post registration curricula was demanded unanimously by senior and middle managers with responsibility for acute and community adult nursing services. The underpinning knowledge base was not defined by this group. However, its importance was stressed by one senior educator:

> "Take IV administration of drugs is a good one, the most important role for the nurse is to observe the effects of that drug, to take nursing actions arising out of the effects of that drug, and to recognise the adverse effects and to intervene where necessary, not the delivery of the drug, it's a simple skill that can be done by a health care assistant. I mean that sounds horrific, even to me as I say it....but actually if they are taught the skills and the risks they can do it. So I don't think it needs nursing knowledge but the other bit does."
>
> (Senior Education Manager)

Management Skills

In addition to the inability to relate clinical theory to practice, there were complaints from managers in both mental health and adult nursing service that Project 2000 graduates lacked basic managerial skills. Specific areas of weakness mentioned by respondents included the confidence to draw up a care plan, manage care in practice, and to undertake practical managerial tasks such as the development of a duty roster:

> "In terms in drawing up care plans or organising a shift they're very apprehensive." (Ward Manager, Acute)

> "They don't really know about how to manage themselves on an everyday basis." (Middle Manager, Mental Health).

> "I think that one of the things that newly qualified nurses lack is any sort of management skills and they don't seem to have a clear understanding of the idea of managing a group of patients or managing a group of staff."
>
> (Middle Manager, Acute)

Several managers expressed a wish that a period of supervised practice (three months was mentioned by three respondents) could be built into training. It is interesting that none of them articulated the fact that this was precisely the period lost from nurse training in the move from traditional training to Project 2000 training.

> "The rest of them do seem to be in need of a lot more support and supervision than previous newly qualified nurses I've come across."

It is reasonable to suppose that the period of preceptorship recommended by the UKCC, and the application of clinical supervision should together address this issue.

Placements

Almost without exception, when educationalists were invited to comment on the issues surrounding the selection of placements, availability was raised as the key concern. This was particularly true of respondents charged with maintaining the supply of

mental health and community placements. The language used, by and large, was not that of moderation:

> "Practice placements are getting so low that you know they'll be non existent soon, I think, it's absolutely dreadful trying to find placements for students, sometimes. I mean I've been ringing places two days before allocation is due to start, saying, please will you take these students, I've got nowhere to send this person." (Educator, Mental Health)

> "Availability is a problem." (Educator, Mental Health)

> "Well the key issue is they've disappeared." (Senior Education Manager)

> "I think the problem perhaps at the moment is the overload." (Senior Manager, Child Protection)

The reasons for this apparent dearth of placements relate primarily to falling bed numbers, with concomitant ward closures. Where patients or clients are grouped together in hospital/residential settings, these areas require staffing over a twenty-four hour period. Thus, for each group of clients who constitute the case load of a nurse, three nurses are required to cover the period and thus six students could theoretically be placed (using ENB ratios of two students to one registered nurse). If all of these patients were transferred home, or moved into unstaffed accommodation in the community, they would be visited by one nurse, who in turn would normally support one student. Thus a community placement will at best support one sixth of the numbers of students of its institutional counterpart. This is, of course a gross over-simplification of the situation, but illustrates some of the factors with which educationalists grapple daily.

Furthermore, there is concern that within mental health at least, community care is under-resourced. This has at least in part arisen from the difficulty of converting capital tied up in large psychiatric hospitals into the revenue required to fund Community Care (CSAG 1995).

Further complicating factors include the fact that where community services and facilities are being developed, they cannot be used immediately for purposes of placement. New teams have to learn to work together and to adopt and refine care planning mechanisms. Only once they have "bedded down" can they be audited and therefore, from a placement point of view, the transition cannot be seamless. Then too, there are philosophical constraints where it is believed that the principle of normalisation does not sit comfortably with the need to provide experience for students. This problem, long an issue in the field of learning disability, was discussed by a small group of mental health teachers and service staff.

Sickness amongst practice supervisors was also raised as a complicating factor. Again, in a hospital setting, it is usual for more than one registered nurse to be on duty. Conversely, the loss of a community psychiatric nurse or district nurse as a result of sickness means the loss of a placement. That this is a significant factor was illustrated by a senior manager responsible for health visiting services:

> "I had 30% absentees a few weeks ago and I am very aware that at the moment that when the students come out they may actually be seeing health visiting in a limited way, because we are actually working to a strategy, to deal with low staffing levels." (Senior Manager, Community)

Educational demands have themselves contributed to the logistical problems. When Project 2000 was introduced, the maximum number of intakes was defined as two per year. This was a substantial reduction for many colleges and entailed the formation of large groups of entrants to the Common Foundation Programmes. In addition colleges were required to consider, in linking with their Higher Education partners, the timing of course intakes to promote integration of students with their Higher education counterparts. For most colleges, this meant the alignment of at least one intake with the commencement of the academic year and thus, for the first time, course structure had other priorities to address than those of the optimum use of placements.

Another constraint raised was a funding issue relating to rostered service. The arrangement in place at the time of the interviews (whereby trusts re-imbursed colleges for rostered service) predated the massive shift of care from hospital to community, and had subsequently created difficulties in placing third year students with community trusts, or GPs, neither of whom were funded for the student contribution. This issue, mentioned by a number of community trust senior managers and educationalists charged with organising community placements was resolved in one region in the study when in 1995 colleges in Northern and Yorkshire region were funded for 100% of bursary payments.

Beyond the issue of funding for rostered service lay the thorny question of payment for placements. This was explored by a number of educationalists who described having reluctantly come to the conclusion that such payments would permit an expansion of placements that was currently denied. The area most often quoted was that of GP practices. One college in the study had already faced the dilemma of finding placements for practice nurses in a market already contaminated by another education provider. This had been resolved by separating out the supervision costs and requiring that the GPs providing placements invoiced the sponsoring GPs directly. The more general argument was:

> "If the money's going towards GPs and GPs want to buy services of district nurses and health visitor or any work group .. will he in actual fact pay for that person to be supporting students, and to be developing those people up?" (Educator)

"It might be a good thing if we did have money to purchase places; and I think it would be a bonus, because then we could go out, and we'd have something to barter for, now we've got nothing. We're really dependent on the goodwill."
(Educator)

"The hospital placements aren't such a problem as community but I think in the future that that will change and I can foresee that as part the providers will want paying for that time for having students." (Nurse Teacher)

One college in the study had recently had the experience of trying to negotiate on behalf of its students placements with charities, Social Services and the Probation Service - all to be applauded in the interests of increasing inter-professional understanding and promoting multidisciplinary working. Here, however, non-availability of funding to support the supervision and assessment of nursing students had been compared with the CCETSW provision for social workers. Who, it was asked, could blame managers who opted to give social work students priority? The recent planning guidance published by the NHSE in relation to non medical education and training (NHSE EL (95) 96) addresses the issue of payment for clinical placements by making the statement:

"It is the NHS Executive policy that NHS bodies should not charge for clinical placements that form an integral part of non-medical education and training programmes." (para 7.2)

It suggests further that:

"Health care purchasers ... may wish to question the vitality of NHS bodies which fail to contribute their fair share to health care professional education." (para 7.2)

It is questionable whether this adequately addresses the contribution of GP fundholders, who run small businesses with a significant degree of autonomy, to the education of nurses and other professionals. The same circular cited above, with its recommendation that social services be represented in the education and training consortia, may, however, facilitate the availability of local authority social services placements for nurses. Conversely, however, such a move would be likely to increase the demand on health placements in respect of social work training. It is to be recommended that the commissioners of education issue explicit advice to care sector organisations on the allocation of placements according to commissioning priorities.

Support for Students in Practice Areas

In addition to resolving the logistical problems, the introduction of payment for placements was suggested as a means of redressing the balance of power between service and education, which in turn could serve to maintain levels of supervision in practice areas. Since the introduction of supernumerary status, it was argued, educationalists have no such lever. In some places, and at some times, the levels of supervision in placement areas was an issue for concern:

"I think in education we sometimes are wary of being idealistic but it is the sharp end and the students are out there." (Educator)

"The key issue is also the inability to provide the sort of supervision that we had, say three years ago because of staff changes. I feel very sorry for them, but that's the world as it is." (Senior Education Manager)

Recent research (Orton 1993; Phillips et al, 1994) has demonstrated that in a cost conscious service the education of students is sometimes seen as a distracter from, and is certainly deemed to be secondary to, the core business of health service provision. Whilst this has always been a source of tension, it was suggested that the changed staffing ratios and the increased turnover had accentuated this.

From the data it emerged that a major preoccupation of education staff was the relentless reduction in the numbers of pre-registration students. "In nursing the balance sheet approach has led to a 33 % cut in training places between 1991 and 1994" (Cole 1994b). Several respondents expressed concern at the future nursing shortage which they confidently predicted. Inevitably the teacher establishment had also declined. (Although the English National Board are currently reviewing the issue of teacher-student ratios, at the time of writing the 1:15 ratio set in the "Regulations and Guidelines" (1993) is still extant and is the figure widely being used to determine the funded establishment at the point of entry into higher education.) Thus, during the life of the study the participating colleges were experiencing an unprecedented drop in the numbers of teachers employed, the downsizing being managed wherever possible by means of early retirement and voluntary redundancy. As a result of this there was some evidence of both teachers and managers in some organisations feeling pressured. The shedding of teachers gathered momentum as contracts were drawn up with the higher education institution with which they were to integrate. During the rationalisation process, steps had been taken to reduce the overall teaching workload in that, where possible, the falling numbers of students had led to a reduction in the overall number of intakes. However, for reasons detailed earlier in the report and known to all readers, the number of available placements was also falling, and this had in some areas mitigated against such efficiency savings in the delivery of education. In any case, as traditional students disappeared and were replaced by Project 2000 students, teaching hours had increased by 50% as the 1533 hours of theory required by traditional courses was replaced by the 2300 hours of Pr t 2000. One of the most frequently expressed concerns related to the decline in number of available teachers, was indeed the available support for students in practice settings:

"It's very difficult to reconcile that (the need to teach students in practice settings) with falling numbers of teachers delivering an increased academic content ... we're carrying vacancies at the moment, we're not replacing people." (Educator)

> "The nurse teachers are getting fewer and yet the students need support and assessment in their practice placements ... fewer teachers around, students spread widely in the community." (Educator)

Thus it appears that despite the ENB's attempt to designate one day per week as time spent in the practical situation, teachers may in fact be less available to students in practical settings than previously. Miller, Tomlinson and Jones (1994) point out that the effectiveness of the teacher as mentor in clinical areas was diminishing as demands increased and tutor numbers decreased. The contracted day per week on the wards of the link teacher, they reported, was not occurring in practice and there were grave concerns about this.

Also, just as Orton (1993) found that the support of students by clinical staff took second place to the care of patients, so in this study it was suggested that the demands of classroom teaching were likely to take precedence over visits to practice areas:

> "I suspect when the chips are down ... if there are thirty people in a room waiting for a lecturer, and it's a choice between that tutor going into service to see students to find out what's going on ... then the thirty people are going to take priority." (Educator)

Given the changes in the role of the nurse as outlined within this study, and of the changing skill base in placement settings it is an issue for concern that teachers may perceive themselves to be less able to support students in practice. In this context, there are concerns around the statement in the above mentioned NHSE planning guidance (NHSE EL (95) 96) that:

> "Education commissioners should explore the scope for securing reductions in the cost pre student in real terms."

Any relaxation of the ENB's regulations around teacher student ratios may be perceived as offering a 'hostage to fortune' in the light of this drive for increased efficiency.

Personal Development

Many educationalists stated that they had expected some degree of skills backlash at some point after the introduction of Project 2000, arising from the greater need at the point of introduction of the new course to establish academic credibility in those higher education institutions who harboured prejudices against vocational education. However, it was more surprising to find that there was criticism of the degree of personal development achieved by students prepared by the Project 2000 route:

> "What I'd like to see nurse training do is to equip nurses with the skills to be assertive, to equip them to be confident, in their own abilities, and not to see themselves as junior partners in any kind of relationship."
> (Middle Manager, Mental Health)

"We get the students coming in as newly qualified nurses, they're very very poor at being able to express their views in an assertive manner."
(Ward Manager, Adult)

"What I see from people coming out of training ... is that they don't actually have much confidence in themselves to nurse, they sometimes, they have quite a lot of knowledge but it.. it often seems to be in the wrong areas."
(Middle Manager, Mental Health)

"It's perhaps something that we've seen coming through here is the lack of confidence in newly qualified nurses." (Middle Manager, Adult)

"I know the last half dozen newly qualified staff nurses that we've taken on which has been in the last two months ... only one of them sticks out as having any confidence at all and that part of duty have had experience as a nursing assistant before she went to her training ... but the rest of them do seem to be in need of a lot more support and supervision than previous newly qualified nurses I've come across.".. (Middle Manager, Mental Health)

"We have just had a big recruitment campaign on and there were some 'D' grade staff nurses been started and very, very, very unconfident and unsure and really need an awful lot of support which is fair enough as they are a newly qualified staff nurse but a lot more than I can remember sort of being the case in the past." (Middle Manager, Mental Health)

This issue of professional self confidence was raised in chapter 6 in relation to the role of the nurse in the multidisciplinary team. One senior manager in an acute trust returned to this issue in discussing the educational implications of the changes required in the role of the nurse:

"I think one of the key areas that we need to spend a lot of time in right at the grass roots is in being able to develop in them that self-confidence, that assertiveness that isn't there at the moment. There is a danger that we build it in for today's students but we forget to alter yesterday's students who are today's sisters." (Senior Manager)

It is, of course a chicken and egg situation. Students can hardly demonstrate self confidence if it is true that their skills development is such as to give rise to real concerns about their ability to perform in the work environment. Practitioners in the focus groups were clear about the relationship between confidence, knowledge and skills:

"In order to be assertive you need a good knowledge base."
(Practitioner, Adult)

"I think a nurse needs a certain confidence to be a valued professional within a multi-disciplinary team. That is built on their knowledge base and experience."
(Practitioner, Adult)

Taken at face value, if confidence is related to knowledge, it is surprising that students who have had an increase in theory within their preparation should exit that training with less self confidence. What the respondents did not suggest, but is at least worthy of consideration is that alerting students to alternative ways of operating, to being "reflexive" renders them less decisive. It may be that students are more aware of what

they do not know, and more mindful of the possible consequences of their actions. This is a hypothesis untested within this study.

Whilst educationalists have undoubtedly a role to play in respect of improving the performance of nurses within the multidisciplinary team, it is assuredly not the whole solution. If educationalists have learned one thing from the many fruitless years spent teaching student nurses to use proper, safe, lifting methods,(if any lifting method can properly be so defined) it is that the processes of professional socialisation are stronger than those of education. It may be that teaching senior students to manage change within the profession will be more powerful than facilitating their skills of assertiveness and addressing their lack of self confidence.

Supernumerary Status

In "Project 2000 - a New Preparation for Practice" (UKCC, 1986) it was argued that supernumerary status was an essential ingredient in addressing the deficiencies of the existing system of nurse preparation. It is instructive to return to the definition used:

> "Names of students should no longer be included on duty rotas, their presence should not be part of the calculation of the number of staff required to carry out the work." (p 54)

The consequences of the acceptance by the Secretary of State of this proposal cannot be overstated. This simple statement freed educationalists to devise educationally coherent sequences of placements without fear of destabilising patient care and to allow reflection to take place in the practice setting. However, it was claimed that those most closely concerned with this 'linchpin of the new training initiative' had clearly not formed an accurate picture of the meaning of the term (Elkan & Robinson 1992). Orton (1993) described the confusion existing around its interpretation, and the present study lends support to these findings. It was postulated that there was a link between the definition of supernumerary as "not there to work" and the poor development of practical skills discussed above. The issue was raised most vociferously, although not exclusively, by mental health managers:

> "I have a little concern that Project 2000 isn't necessarily equipping the nurses with the skills to be able to function effectively ... with our students that come through that are supernumerary. They'll sit back and they'll watch and they'll observe ... There seems to be a reluctance by students to take on all that responsibility because they see themselves as supernumerary, they're there to observe what the practitioner is doing, what the nursing staff's doing."
> (Senior Manager, Mental Health)

> "Two stand out particularly that actually wanted to, they felt they could learn more by if you like sitting in the background and watch what's happening, and we strongly suggested that if they came on the placement that they would actively ..be part of the team." (Middle Manager, Mental Health)

The same manager went on to suggest that ward staff were culpable in permitting this to happen, but suggested a rationale for this stance:

> "There's a lot of reticence from ward staff, they tend to feel that all supernumerary means they don't get involved, they're there just to watch and do what they want to do ... I think the staff reinforce that misconception about what supernumerary status is." (Middle Manager, Mental Health)

> "They'd come here just in the middle of their third year, and if they've gone that way, then obviously along the way they've treated the same, they've not been asked, encouraged to join the team, and that to me is wrong."
> (Ward Manager, Mental Health)

> "In some ways it makes it easier for everyone if they're not accountable, you then don't have to worry about supervising what they're doing ... you just say, 'No you're not allowed to do that'."
> (Middle Manager, Acute)

It was suggested by respondents that there was a need to clarify what is meant by supernumerary status. It may be argued that an altogether more radical step be taken. Whilst it was crucial that the concept be well understood at the time of introduction of Project 2000, ensuring that the student's experience was education led, it can be argued, that for current and future students and clinical mentors, an understanding of the concept is redundant, and that in seeking to make sense of it, students are in danger of finding ways to differentiate themselves from other staff in the practice areas. A (false) interpretation of supernumerary status may actually compromise learning opportunities. Students of teaching and social work do not have recourse to the term; they are, simply, 'students.' As all nurse education moves into higher education, it could be suggested that this is the ideal time to celebrate a past battle by embracing a new understanding of the word 'student'. It is readily recognised that this suggestion may well cause some consternation amongst some educationalists. As Ball (RSA, 1991) remarks:

> Change is awkward, for the status quo represents security; even when its utility has passed it may be preserved because it was once useful. Judging the moment when structures and concepts have outlived their usefulness is always difficult. (P5)

There was a time, however, when 'five new pee' became, simply, 'five pence.'

Shared Learning

There was a lively interest amongst both educationalists and service managers in the concept of shared training. Several suggested that there was a common core of knowledge relevant for nurses and the other professionals allied to medicine:

> "They will redefine the shared functions and those will become a common foundation for everyone, and then you'll say, now these people are going to exclusively concentrate on rehabilitation, you know like the OT's and physios do." (Educator)

As colleges of nursing integrate with higher education the potential for common and shared training with other health care professionals will increase. The training courses may be longer in the future and it is suggested that trusts may see this as an efficient way of securing nurses and health care professionals who are more fully prepared to meet the challenges of health care today. Of those who raised this subject, none doubted that such a change would take place although the precise time scale remains unclear. Just as there are difficulties in inter-agency working in clinical practice so, according to respondents, are there challenges in the organisation of inter-agency shared training. A senior education manager informed us:

> "I've talked to physios and OT's and those who manage the service tell me that it will happen, their view is that it will happen and they're very concerned about nursing taking them over, so there's going to be a political battle about it, but the UKCC aren't helping us very much at the moment.".
>
> (Senior Education Manager)

> "I can't see us all going on much longer - all being taught separately."
>
> (Senior Manager, Adult)

It was recognised that professional boundaries are challenged by the concept of such programmes. The view was expressed that the profession of nursing must, if it is to remain a potent source of power and influence in health care, advance with this agenda. The same senior education manager quoted above expressed her aspirations to run an early generic training scheme at pre-registration level:

> "I see the generic training being pre-registration when it comes. It might be fifteen years but there'll be moves towards that, someone is going to, and I wanted us to be it, but somebody is going to run a scheme soon, I was wanting to run a sort of pilot scheme, but ... it was just a sort of bit advanced."
>
> (Senior Education Manager)

Many educationalists within the study were currently engaged in shared learning at post-registration level. However, the same people cited difficulties concerning its inclusion into pre-registration education programmes. One of the most obvious barriers was that of differing academic levels between nursing courses and those degree programmes in which other health care professionals were engaged. Students could not join together at the commencement of the course because medical students PAMs and social workers, who met university matriculation requirements, immediately entered level 1 study, normally with A levels in such areas as biology; whereas entrants to diploma level nurse education had an introductory period at access level. This disparity of levels made curriculum integration difficult to bring about, unless artificially high entrance requirements were imposed.

Implicit in the concept of multidisciplinary learning is the expectation of nursing as an all-graduate profession. Senior Managers and educators alike speculated that the student nurses of the future would graduate at first degree level. The respondents did not specifically express an opinion on this potential change but they agreed that a

sound and extensive knowledge base and an intellectual capacity were vital to discharge the functions of the nurse. In discussions about multi-disciplinary team working, there was recognition and enthusiasm amongst professional nurses for the acquisition of a formally tested comprehensive theoretical knowledge base that is comparable with other health care professionals:

> "I just automatically expect the few professionals that will be about will be of graduate status. That'll come about slowly but it'll certainly come." (Educator)

If this is an accurate prediction,(and with the advent of the three year nursing degree who can doubt it) this will, *de facto*, solve the issues of academic equivalence cited above.

Community Emphasis and Community Skills

Inevitably, much of the content of this section relates directly to the changing role of the practitioner outlined in chapters 3 and 4. Occasionally, managers addressed their comments specifically to pre- or to post-registration education; more often they made a general statement for inclusion. Even where pre-registration education was cited as the appropriate place to address these developing skills, it was recognised that for current practitioners these developing skills would have to be provided at post registration level. Many respondents refer to the traditional emphasis of nurse education as being that of the hospital context which had left practitioners ill prepared for community nursing. As care is increasingly offered in the community setting, a knowledge of health needs assessment and skills in care management is viewed as vital. As increasing numbers of D and E grade staff nurses are employed in the community, and as outreach services increase, questions will inevitably be raised about the balance of community preparation in the pre-registration curriculum, and in the purpose and value of post registration community qualifications. The issue was introduced earlier with reference to the recommendation of Butterworth that the differential titles of community and hospital mental health nurses should cease. A senior nurse manager responsible for mental health services was unequivocal on this point:

> "What I can't reconcile in my own mind is why CPNs, as they are nowadays, require an extra twelve months training, and certainly any outcome of training in the future must equip someone to work in all the different environments and not just the hospital." (Senior Manager, Mental Health)

As part of this education, there had to be an attempt to develop greater self confidence and improved decision making skills. As indicated above, professional judgement, and education in risk management and risk assessment were integral components of this shift of care to the community.

There is a sense in which nurses have always assessed risk, and been charged with the responsibility of communicating concepts of risk to clients. However, practitioners are increasingly required to adopt a systematic approach to the assessment and management of risks to and from clients. It is axiomatic that the underpinning knowledge and skills must be addressed in pre-registration education and nowhere is this felt to be more urgent than in the field of mental health. For the purposes of this study, not the least important aspect of risk assessment was in relation to the decision to allow students to visit clients at home under indirect supervision. The point was expressed by a senior manager responsible for mental health services:

> "Nurses have got to take more responsibility rather than just say 'Is it all right for these students to visit patients by themselves?' That is not the question. They should say, 'I feel that this nurse can deal with this patient and I take responsibility for this decision ... provided you've got some systematic risk assessment." (Senior Manager, Mental Health)

Certainly, visits by students to families under indirect supervision was the practice in some of the colleges and trusts in the study.

It was stated that for all practitioners, and especially for those working in the community, an increased understanding of the roles of the various members of the multidisciplinary team is a pre-requisite to effective working. A community manager responsible for health visiting and district nursing services expressed concern about the lack of understanding of the roles of the various members of the primary health care team. This he considers to be a key requirement for the nurse in the future:

> "I still find nurses who don't really understand what really is a primary health care team ... I think a key thing in terms of an awareness of and skills related to that is a function of the primary health care team and what the nurse's role is in that and what each member of the teams role is in that, and how they link in to secondary services to acute setting." (Senior Manager, Adult)

These hopes were re-iterated by another senior manager for community and child services who stressed that all practitioners, without further training should have an appreciation of the needs of carers and of the real impact on, for example, the family who care for a child with a chronic disorder:

> "I'd like much more children in the community sort of work, whether that means just going into the homes when children have long term conditions and talking through the parents what that's all about, the impact that that has on some of them in terms of not having a career or you can't get the ordinary baby sitter in, it has to be a baby sitter who can give oxygen and that sort of thing." (Senior Manager, Community)

Many other respondents made reference to the need for nurses to be aware of the whole range of community services available to support the patient and the family at home. Whilst it was recognised that a comprehensive working knowledge of such systems might not be feasible at pre-registration level, all nurses must be aware of

the main services available and demonstrate ability to access these on the client's behalf.

8.0 ***Key Issues***

8.1 Educationalists stressed the need, highlighted by the ACE Report (Phillips et al, 1994), to maintain regular liaison between educators and practice placement areas. It is recognised that, as structures change in both colleges and service organisations, constant vigilance is required to ensure effective contact

8.2 The term 'supernumerary status' is an occasional source of confusion to students and clinical staff and, other than in financial and managerial contexts, should fall into disuse. Now that students are clearly bursaried members of a university and not employees of a trust, the word 'student' should adequately convey that they, like their teaching and social work counterparts, are placed in patient/client areas for the achievement of learning outcomes. One of these is to act as a fully participative member of the ward team.

8.3 Concerns were expressed by managers and educators alike regarding skills development in both adult and mental health branches. This was variously attributed to:

- the reduction in exposure to practice in the diploma programme as compared with traditional nurse training;
- the time available for teaching in the practice setting where skill mix reviews have resulted in a reduction in qualified staff;
- reduced numbers of teachers with increasing workloads who are less available to teach in practice settings.

Colleges should consider establishing clear contracts with trusts which set out the responsibilities of teachers and clinical mentors in the teaching of skills.

8.4 As a minimum requirement managers requested that the following skills, with the necessary underpinning knowledge, should be included in pre-registration curricula without delay:

- venepuncture;
- intravenous administration of drugs (excluding first dose and cyto-toxic drugs);
- insertion of peripheral IV cannula.

8.5 There is a perception by service managers that students completing Project 2000 programmes lack self confidence. This may be in part attributable to the poor skills development cited above.

8.6 There is a sense in which nurses have always assessed risk, and been charged with the responsibility of communicating concepts of risk to clients. However, practitioners are increasingly required to adopt a systematic approach to the assessment and management of risks to and from clients. It is axiomatic that the underpinning knowledge and skills must be addressed in pre-registration education. Nowhere is this felt to be more urgent than in the field of mental health.

8.7 Many respondents made reference to the need for nurses to be aware of the whole range of community services available to support the patient and the family at home. Whilst it was recognised that a comprehensive working knowledge of such systems might not be feasible at pre-registration level, all nurses must be aware of the main services available and demonstrate ability to access these on the client's behalf.

8.8 In addition to the inability to relate clinical theory to practice, there were concerns amongst managers in both mental health and adult nursing services at the lack of basic managerial skills found in Project 2000 graduates. Specific areas of weakness mentioned by respondents included the confidence to draw up a care plan, manage care in practice, and to undertake practical managerial tasks such as the development of a duty roster.

8.9 The NHSE letter EL(95)96, with its recommendation that social services be represented in the education and training consortia, may facilitate the availability of local authority social services placements for nurses. Conversely, however, such a move would be likely to increase the demand on health placements in respect of social work training. It is to be recommended that the commissioners of education issue explicit advice to care sector organisations on the allocation of placements according to commissioning priorities.

8.10 If teacher student ratios are to be withdrawn, monitoring work must be undertaken to assess the effects of de-centralised control on both the teaching of theory and of practice.

8.11 It was with regret that many of the educationalists interviewed recognised the advantages which would be conferred were they to have resources with which to purchase placements. The guidance issued by the NHSE (EL 95/96) is welcome in this respect, but does not resolve the difficulties in securing sufficient valuable experience within GP practices, for which many require payment.

The detailed account of the derivation of the competency statements tested by the two questionnaires and details of the sampling methods are given in Chapter 1. A total of 630 questionnaires (285 mental health and 345 adult) were distributed and 419 completed forms were returned representing a total response rate of 66.5% (see table 1). The sample size for mental health nurses in community settings was restricted by the fact that the whole population was less than the projected sample size. Whilst this was lower than the rate the pilot study had achieved, it is an acceptable response rate for a national postal survey. Indeed, given the complexity of the survey instrument, which asked for three responses for each competency statement and had a mean completion time of thirty five minutes, the rate is higher than might reasonably have been assumed. (Questionnaires are at appendices d and e).

Table 1: Questionnaire Responses

Area of practice	Sample Size	n	Response %
Mental Health Nursing Hospital and Residential Settings	150	86	57
Mental Health Nursing Community Settings	135 (total pop)	96	71
Adult Nursing Hospital Settings	150	97	65
Adult Nursing Community Settings	150	108	72
Practice Nurses	45	29	64
Not Known	-	1	-
Totals	630	419	66.5%

Respondent Profile

A biographical data sheet was completed as part of the questionnaire. Tables 2 to 6 summarise the sample composition with respect to care setting, gender, grade and job title. Table 7 summarises the means for the length of time the respondents had been qualified, and in their current posts. This data allows for comparison with national profiles of nurses in post.

Table 2: Care Setting (Community/Hospital) for the Sample.

	Adult n %	Mental Health n%	Total
Community	115 (50.4)	86 (46)	201
Hospital	93 (40.8)	74 (39.6)	167
Both	10 (4.4)	22 (11.8)	32
Other	10 (4.4)	5 (2.7)	15

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Table 3: Sample by Gender Composition

	Adult n (%)	Mental Health n (%)	Total n (%)
Male	9 (3.9)	68 (36.4)	77 (18.6)
Female	217 (95.2)	119 (63.6)	336 (81)

Table 4: Sample by Grade Composition

Grade	Adult n (%)	Mental Health n (%)	Total n (%)
D	41 (18.1)	28 (15.2)	69 (16.8)
E	49 (21.6)	75 (40.8)	124 (30.2)
F	34 (15)	26 (14.1)	60 (14.6)
G	81 (35.7)	46 (25)	127 (30.9)
H	18 (7.9)	7 (3.8)	25 (6.1)
I	2 (0.9)	2 (1.1)	4 (1)
Other	2 (0.9)	-	2 (0.5)

Table 5: Sample by Job Title (Adult Sample)

Job Title	n (%)
Practice nurse	28 (12.3)
Staff nurse	86 (37.7)
Ward manager	19 (8.3)
Unit manager	3 (8.3)
Health visitor	39 (17.1)
District nurse	23 (10.1)
Clinical nurse specialist	7 (3.1)
Other	23 (10 1)

Table 6: Sample by Job Title (Mental Health Sample)

Job Title	n (%)
Staff nurse	99 (52.9)
Ward manager	18 (9.6)
Unit manager	6 (3.2)
Clinical nurse specialist	4 (2.1)
CPN	42 (22.5)
Other	18 (9.6)

Table 7: Mean Length of Time Qualified, and in Current Post (in Years).

	Adult (Standard Deviation)	Mental Health (Standard Deviation)	Total (Standard Deviation))
Mean length of time qualified	17.20 (9.95)	11.56 (8.04)	14.66 (9.55)
Mean length of time in post	6.82 (6.06)	4.16 (4.09)	5.63 (5.43)

Analysis of the Findings

The purpose of the analysis was to identify trends in nursing competence, and to identify the most appropriate placements in which the competencies tested could be achieved by student nurses.

The specific research questions addressed within this phase of the study were:

- To what extent are the selected competencies regularly performed by practitioners?
- Are the selected competencies more likely to be addressed in hospital or community settings?
- Is there any group of placement areas in which these competencies are more likely to be addressed?
- Is the frequency of demonstration of these competencies significantly related to grade?
- Which of the competencies tested are perceived by practitioners to be important for their role in the future?
- Which of the competencies do practitioners view as being relevant outcomes for pre-registration education?

Respondents were asked:

- How **regularly** they carried out the given competence - Regularly, occasionally or never?
- How **important** this competence was for their role in the future on a scale of 1 to 5? (When 1 = ' of no importance' and 5 = 'vital')
- Whether this competence should be an outcome of **pre-** or **post-**registration education.

The competencies tested in the survey were subjected to statistical interrogation in relation to cruciality, setting, area of practice and grade. The results are presented as a complete "map" of the nursing competencies in Tables 9 (mental health) and 10 (adult).

Cruciality

The issue of cruciality, a concept devised for the purposes of this study, has two dimensions. The cruciality ratings were the percentage of respondents giving a positive response to each of the questions 'how regularly?' and 'how important?'

- **Current Cruciality (Cruciality C)**

  An indicator was developed to reflect how *regularly* the element of competence was addressed in current practice - its *current* cruciality. This statement of priority offers evidence to help educationalists and service managers to identify likely settings, areas of practice, and grade related characteristics which will provide the required clinical experience for students.

- **Predicted Cruciality (Cruciality P)**

  This indicator explores the extent to which the item of competence is viewed as *important* for the respondents' *future* role. Given the importance of discourse and professional consensus in defining social 'truths' related to the nature and components of occupational competence, this future dimension provides a baseline for evaluation and planning.

In addition to exploring the boundaries of nursing practice, the study was required to identify competencies which differentiate hospital and community practice, and to offer advice on the optimum practice placements in which the competencies can be achieved. In order to answer the first of these questions a Kruskall-Wallis non-parametric analysis of variance for ordinal data (corrected for ties) was carried out to distinguish those elements of competence for which an overall significant effect occurred between settings. Subsequently, Mann-Whitney U tests were carried out in order to identify the significant effects between specific settings within the overall two-way significant effect proffered by the Kruskall-Wallis test.

Care Setting

The qualitative component of the study highlights the changing nature of the traditional boundaries between hospital and community care. Managers interviewed were hopeful that the broader education provided by the diploma level pre-registration course, with its emphasis on social issues and health promotion, would fit practitioners to operate effectively in either setting. It was the aim of this section to fulfil two functions. Firstly, it offers some empirical 'clarity' to the qualitative picture painted thus far in the report. Secondly, it addresses some of the questions raised by the changing contexts described above. That is, what are the areas of commonality and divergence between hospital/residential and community care settings for the adult and mental health samples.

The statistical significance of findings related to practice settings is indicated in statistical appendices 1 and 2 in volume 2. Because of the number of elements of competence identified by the qualitative study and subsequently included in the questionnaire tool, it was decided to concentrate only on those for which the differences between settings were deemed statistically significant. That is, the probability of gaining the result demonstrated by chance was less than 5%. It is recognised that were the researchers to present only those statements for which a significant difference was found there is a danger of excluding those elements which while not *statistically* significant are nevertheless *theoretically* significant. An attempt has been made to overcome this common problem by identifying all elements of competence in the map (Tables 9 and 10).

Area of Practice

The areas of practice used in the survey were derived from those chosen by the UKCC to collect PREPP data, but their number (42 in the adult questionnaire; 15 in the mental health) gave rise to cell sizes too small for statistical analysis. It therefore proved necessary to condense the coded categories as listed below (table 8). The statistical significance of findings related to areas of practice is indicated in statistical appendices 3 and 4 in volume 2, and is summarised in the map (tables 9 and 10).

Table 8 Condensed Categories for Areas of Practice

Sample	UKCC Areas of Practice	Collapsed Category
Adult	A&E and acute admissions	A&E /acute
	Anaesthetics, theatres, other (non-specific), management, admin, outpatients, paediatrics, family planning	Other
	Community hospital, community nursing, GP practice (fundholder and non-fundholder), practice nursing, schools	Community nursing
	Day surgery, ENT, general surgery, GU surgery, gynaecology, neurology, orthopaedics	Surgical
	Diabetic, general medicine, oncology, palliative care, renal	Medical areas
	Coronary care, ITU, SCBU	Critical care
Mental Health	Child, adolescent and child/adolescent	Child/adolescent
	Neuro psychiatry, substance misuse	Other

All other categories were as named in the biographical data sheet and in the Map.

Grade

The analysis sought to determine whether there were any significant differences relating to the grade on which practitioners were employed. If so, it would be possible for educationalists to ensure that mentors for students were appropriately selected. For this question a contingency table was constructed for each element and a Pearson's chi-square test for independence was applied to highlight the statistical significance of the attached to each group of nurse grades. (Details are presented in statistical appendices 5 and 6 in volume 2.)

The Map of the Elements of Competence in Adult and Mental Health Nursing.

The aim of this section of the report is to put forward a schema or 'map' of the optimal settings, areas of practice and nurse-grade group in which students are most likely to observe the selected elements of competence regularly. The schema will also give an indication of the 'cruciality' for each of the elements of competence in a format which facilitates ease of access and comparison between the contemporary and predicted aspects of the element (ie current frequency of performance *versus* importance for the future). Each statement of competence is mapped individually for both adult and mental health samples. In cases where there are no clearly significant results this is indicated in the table.

Key to Map

Column 1 - ***Competence Number***

Column 2 - ***Statement of Competence***

Column 3 - ***Cruciality C -*** indicates the percentage of respondents carrying out this competence regularly

Column 4 - ***Cruciality P -*** indicates the percentage of respondents who believe this competency will be important in the future

Column 5 - ***Setting -*** indicates any statistically significant difference in the incidence of this competence between hospital and community

* = Insufficient evidence to suggest a difference between settings

Column 6 - ***Area of Practice*** - indicates the practice areas where this competence is most likely to be observed

** = Insufficient evidence to suggest a difference between areas of practice

Column 7 - ***Grade -*** indicates the grade of nurse most likely to demonstrate this competence

*** = Insufficient evidence to suggest a difference between nurse grades

Table 9 ***Map of Elements of Competence***

Mental Health Sample

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
1.0	**CONTEXT OF CARE**					
1 1	Having patient/client contact in both hospital and community settings	30	40	Community, Both	Child & Adolescent Serious & Enduring	t/g (C) *** (H)
1 2	Undertaking practice sensitive to the needs of patients/clients from multi-cultural backgrounds	23	48	Hospital	**	***
1 3	Working in conjunction with the voluntary and private sector	31	36	Community, (Other)	Day Care	t/g (C) *** (H)
1 4	Negotiating and retaining access to patient's/client's homes	30	34	Community, Both	Child & Adolescent Serious & Enduring	t/g (C) *** (H)
1 5	Undertaking nursing practice in settings physically remote from colleagues	31	28	Community, Both	**	***
1 6	Challenging institutional practices	40	56	*	Forensic Community Unit	***
1 7	Contributing to the care of patients/clients who are homeless	18	26	Hospital	Acute Serious & Enduring	***
1 8	Contributing to the care of patients/clients undertaking custodial sentences	10	11	Hospital	Forensic	***
1 9	Contributing to the care of patients/clients who are subject to probation orders	6	12	Hospital Both	Forensic	***
1 10	Working with a patient/client who exhibits challenging behaviour	64	66	Hospital	**	***
1 11	Fostering autonomy of patients/clients in relation to health care decisions	67	64	*	**	***
2.0	**PATIENT/CLIENT CENTRED CARE**					
2 1	Maintaining and monitoring long term relationships with individuals, families or other social groups for health maintenance	57	59	Community, Both	Serious & Enduring Elderly Community Unit	t/g (C) *** (H)
2 2	Making appropriate referrals when patients/clients seek legal advice	16	27	Hospital	**	***
2 3	Acting as patient/client advocate regarding quality of life issues	54	59	*	**	***
2 4	Drawing up contracts of care with individual patients/clients	63	65	*	Day Care Child & Adolescent Serious & Enduring Acute Community Unit	h/i (C) *** (H)
3.0	**CLINICAL ASSESSMENT**					
3.1	Undertaking comprehensive health care needs assessment of individuals	81	80	*	**	h/i (C) t/g (H)
3 2	Undertaking comprehensive health care needs assessment of families	20	35	Community Both	Child & Adolescent CUE	h/i (C) *** (H)

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
3.3	Undertaking comprehensive health care needs assessment of communities	5	15	*	**	f/g (C) *** (H)
3.4	Assessing social/life skills	60	71	*	**	f/g (H) *** (C)
3.5	Assessing neurological function	20	30	*	Elderly CUE	***
3.6	Taking the final decision to admit patients/clients to hospital within protocol criteria	17	37	*	**	h/i (C &H)
3.7	Making a daily assessment of all clients for whom I am responsible	72	70	Hospital	**	d/e (C) *** (H)
3.8	Recognising the effects of prescribed drugs and drug interactions	85	85	Community, Hospital	All except Child & Adolescent	f/g (H) *** (C)
3.9	Carrying out physical assessment of patients/clients	50	52	*	CUE	***
4.0	**NURSING ACTIONS**					
4.1	Making and acting upon decisions which carry risks to patients/clients	51	68	*	**	***
4.2	Making and acting upon decisions which carry risks to families	20	43	Community, Both	**	***
4.3	Making and acting upon decisions which carry risks to communities	10	32	*	**	***
4.4	Making and acting upon decisions which carry risks to the organisation	27	39	All exce (Other)	**	h/i (C) *** (H)
4.5	Making and acting upon decisions which carry risk to self	29	60	*	**	***
4.6	Transporting drugs outside hospital premises	20	32	Community	Serious & Enduring Day Care Elderly	f/g (C) *** (H)
4.7	Administering and disposing of medicines (including controlled drugs) outside the hospital situation	18	36	Community	**	f/g (C) d/e (H)
4.8	Interpreting and applying Health and Safety legislation	66	60	*	**	***
4.9	Interpreting and applying The Community Care Act	52	60	*	**	***
4.10	Interpreting and applying The Children Act	6	20	*	Child & Adolescent	h/i (C) (occasionally)
4.11	Interpreting and applying The Mental Health Act	53	71	Hospital	Forensic Acute Serious & Enduring	***
4.12	Attending court hearings/tribunals and engagement with the Criminal Justice System	2	14	Hospital	Forensic	h/i (C) (occasionally)
4.13	Attending meetings called for the purpose of child protection	5	21	*	Child & Adolescent	h/i (C) *** (H)
4.14	Allocating patients/clients to diagnostic groups on the basis of which treatment is initiated	25	32	*	**	h/i (C) *** (H)
4.15	Facilitating group therapy meetings	30	40	*	Day Care Community Unit	***

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
5.0	**SPECIFIC NURSING SKILLS**					
5.1	Adjusting patient medication in response to laboratory findings	4	25	*	**	***
5.2	Interpreting blood results and adjusting treatment accordingly	1	25	*	**	***
5.3	Confirming expected death	2	17	*	CUE Elderly	***
5.4	Prescribing drugs within protocols	6	20	Hospital Both	**	***
5.5	Being accountable for and personally administering electro-convulsive therapy	1	7	*	**	***
5.6	Assessing, anticipating and diffusing aggression	52	79	Hospital Both	**	***
6.0	**CLINICAL EVALUATION**					
6.1	Using computer held data to inform the evaluation of client care outcomes	5	15	*	**	***
6.2	Undertaking evaluation strategies with the use of audit tools	19	26	*	**	h/i (H) *** (C)
6.3	Accessing local databases held on computer	6	14	*	**	d/e (C) h/i (H)
6.4	Accessing national databases held on computer	1	10	*	**	h/i (C) *** (H)
6.5	Planning systems of nursing activity which satisfy agreed standards at local, unit or district level	41	37	*	**	***
6.6	Evaluating quality improvements to assure the on-going quality of nursing services	41	45	*	**	h/i (C) *** (H)
6.7	Participating in multi-disciplinary clinical audit	26	40	Community, Both	**	***
7.0	**MULTI-DISCIPLINARY WORKING**					
7.1	Actively participating in multi-disciplinary team meetings	81	79	Community, Both	**	f/g /h/i (C) *** (H)
7.2	Actively working with social workers	55	57	*	**	f/g (C) *** (H)
7.3	Actively working with occupational therapists	64	54	*	CUE Serious & Enduring	f/g (C) h/i (H)
7.4	Actively working with chiropodist/podiatrists	6	13	*	CUE	***
7.5	Actively working with dieticians	6	20	*	**	***
7.6	Actively working with consultants	75	72	*	**	***
7.7	Actively working with psychologists	29	47	*	Forensic Child & Adolescent Day Care	***
7.8	Actively working with GPs	41	56	Community, Both	CUE Child & Adolescent Serious & Enduring	***
7.9	Actively working with pharmacists	46	44	*	CUE Community Unit Forensic	***

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
7.10	Participating in meetings in which decisions are made regarding selection of key workers	56	55	Community, Both	**	h/i (C) *** (H)
7.11	Co-ordinating the multi-disciplinary team in discharge planning	44	58	*	**	h/i (C) *** (H)
7.12	Participating in multi-disciplinary standard setting	28	44	Community, Both	**	***
7.13	Participating in the writing of shared protocols for care	30	41	*	**	***
7.14	Collaborating with the multi-disciplinary team in reaching clinical decisions in ethically challenging situations	29	54	*	**	h/i (H) *** (C)
7.15	Contributing to shared multi-disciplinary team patient notes/records	54	56	*	**	***
7.16	Actively working with probation officers	2	11	Hospital Both	Forensic Day Care	f/g (C) (occasionally) *** (H)
7.17	Collaborating with the multi-disciplinary team in delivery of the care programme approach	63	69	*	**	f/g (C) *** (H)
8.0	**RESEARCH**					
8.1	Identifying researchable problems	6	15		**	***
8.2	Writing or collaborating in writing a research proposal	4	19	*	**	d/e (C) *** (H)
8.3	Communicating research findings to staff through formal and informal processes	11	28	*	**	h/i (H) *** (C)
8.4	Effecting change based on research findings	8	36	*	**	h/i (H) *** (C)
8.5	Critically analysing the findings of research studies	7	31	*	**	d/e (H) *** (C)
9.0	**PERSONAL & PROFESSIONAL DEVELOPMENT**					
9.1	Completing reflective diaries	15	29	*	**	***
9.2	Maintaining a personal and professional portfolio	25	55	*	All except Community Unit	h/i (C) *** (H)
10.0	**EDUCATION**					
10.4	Undertaking **informal** health education activities with individuals	57	55	*	**	***
10.5	Undertaking **informal** health education activities with families and carers	32	46	*	Child & Adolescent CUE Serious & Enduring Forensic	h/i (C) *** (H)
10.6	Operating as a mentor for students and staff	56	65	*	**	f/g (C) h/i (H)
10.7	Assessing National Vocational Qualifications (NVQ) competencies	8	29	Hospital Both	**	h/i (H) *** (C)
10.8	Assessing student nurses	44	70	*	**	f/g (H) *** (C)
10.9	Participating in a process of clinical supervision	50	67	*	**	***

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
10 10	Disseminating information about educational resources and opportunities	33	44	*	**	h/i (C) f/g (H)
11.0	**MANAGING CHANGE**					
11 1	Contributing to meetings regarding the business strategy of the Trust	12	30	*	**	h/i (C & H)
11 2	Contributing to meetings at which broad professional issues are discussed	18	37	Community, Both	**	h/i (C & H)
11 3	Formally presenting a case for change	9	34	Community, Both	**	h/i (C & H)
12.0	**MANAGEMENT**					
12 1	Reviewing workload priorities as a response to changing contexts	47	56	*	**	f/g (H) *** (C)
12 2	Monitoring the actions of others to whom responsibility for patient/client care has been delegated	55	68	Hospital Both	**	h/i (C) *** (H)
12 3	Managing the allocation of patients/clients to a multi-skilled team	46	55	Hospital Both	Day Care Community Unit CUE Acute Forensic	***
12 4	Managing care within the context of change	59	63	*	**	***
12 5	Dealing with formal requests for information from **organisations** outside the National Health Service	17	28	*	**	h/i (C & H)
12 6	Chairing meetings	15	19	Community, Both	**	h/i (C & H)
12 7	Inputting data to computerised information management systems	11	16	Community	**	h/i (C & H)
12 8	Managing a budget	11	21	*	**	h/i (C & H)
12 9	Managing personnel issues and policies	23	29	Both	**	h/i (C) f/g (H)
12 10	Negotiating a care package for individual patients/clients	61	72	*	**	***
12 11	Taking the final decision to discharge patients/clients within defined protocols	31	48	Community	**	h/i (C & H)
12 12	Writing discharge letters to GPs	36	46	Community	Day Care Serious & Enduring CUE Child & Adolescent Elderly	h/i (C) d/e (H)
12 13	Managing nurse led clinics	13	31	Community, Both	**	h/i (C) *** (H)
13.0	**COMMUNICATION**					
13 1	Establishing an informal, relaxed working relationship with a patients/clients	94	89	*	**	f/g (C) *** (H)
13 2	Establishing a therapeutic relationship with a patient/client who presents with a history of sexual abuse	26	56	Hospital	All except Elderly & CUE	***

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
13.3	Working within a framework of an established model of counselling	41	50	Community	Child & Adolescent Acute Serious & Enduring	h/i (C) *** (H)
13.4	Using a formal model of counselling	27	42	*	Child & Adolescent Acute Serious & Enduring	h/i (C) *** (H)
13.5	Giving formal counselling supervision	17	36	*	**	h/i (C) *** (H)
13.6	Handling catharsis	26	41	*	**	h/i (H) *** (C)
13.7	Establishing a trusting relationship with a client who finds trust difficult	70	77	*	**	***
13.8	Dealing personally with patients, their families or carers who make a complaint	12	60	*	**	h/i (C) *** (H)

Table 10 Map of Elements of Competence

Adult Sample

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
1.0	CONTEXT OF CARE					
1.1	Having patient/client contact in both hospital and community settings	17	26	Community, Both	Elderly Community areas	***
1.2	Undertaking practice sensitive to the needs of patients/clients from multi-cultural backgrounds	31	25	Community	Community areas	***
1.3	Working in conjunction with the voluntary and private sector	28	25	Community	Community areas	***
1.4	Negotiating and retaining access to patient's/client's homes	40	41	Community	Community areas	***
1.5	Undertaking nursing practice in settings physically remote from colleagues	40	37	Community	Community areas	***
1.6	Dealing with issues related to public health	38	50	Community, Both	**	h/l (C) *** (H)
1.7	Undertaking health screening programmes	40	50	Community	Community areas Elderly	f/g (C) *** (H)
2.0	PATIENT/CLIENT CENTRED CARE					
2.1	Fostering autonomy of patients/clients in relation to health care decisions	67	66	Community	Elderly Community areas Medical Surgical	***
2.2	Maintaining and monitoring long term relationships with individuals, families or other social groups for health maintenance	61	63	Community	Elderly Community areas Medical	f/g (C) *** (H)
2.3	Making appropriate referrals when patients/clients seek legal advice	9	26	*	**	***
2.4	Acting as patient/client advocate regarding quality of life issues	42	56	*	**	***
2.5	Participating in decisions related to resuscitation based on quality of life indicators	12	32	Hospital	Medical Surgical A & E Critical Care	***
3.0	CLINICAL ASSESSMENT					
3.1	Undertaking comprehensive health care needs assessment of individuals	82	78	*	** (other)	f/g (C) *** (H)
3.2	Undertaking comprehensive health care needs assessment of families	39	50	Community, Both	**	f/g (C) *** (H)
3.3	Undertaking comprehensive health care needs assessment of communities	14	25	Community	Community areas Elderly	f/g (C) *** (H)
3.4	Assessing social/life skills	52	49	*	**	***
3.5	Assessing neurological function	22	36	Hospital	A & E	***
3.6	Taking the final decision to admit patients/clients to hospital within protocol criteria	6	20	*	**	***

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
3.7	Making a daily assessment of all clients for whom I am responsible	53	57	Hospital Both	Critical Care Medical Surgical	d/e (C) *** (H)
3.8	Recognising the effects of prescribed drugs and drug interactions	63	72	Hospital Both	Medical Surgical A & E Elderly Critical Care	***
3.9	Carrying out physical assessment of patients/clients	67	70	Hospital Both	A & E Elderly Medical Surgical	d/e (H) *** (C)
4.0	NURSING ACTIONS					
4.1	Making and acting upon decisions which carry risks to patients/clients	40	52	*	**	***
4.2	Making and acting upon decisions which carry risks to families	14	31	Community, Both	Elderly A & E Community areas	***
4.3	Making and acting upon decisions which carry risks to communities	3	16	Community, Both	Elderly Community areas A & E	f/g (C) *** (H)
4.4	Making and acting upon decisions which carry risks to the organisation	8	18	*	**	f/g (H) *** (C)
4.5	Transporting drugs outside hospital premises	3	20	[illegible]nity, [illegible]	Community areas Elderly Critical Care	h/i (C) f/g (H)
4.6	Administering and disposing of medicines (including controlled drugs) outside the hospital situation	21	36	Community, Both	Community areas	***
4.7	Interpreting and applying Health and Safety legislation	58	62	*	Medical Surgical A & E	***
4.8	Interpreting and applying The Community Care Act	34	43	Community, Both	Community areas A & E Elderly	h/i (H) *** (C)
4.9	Interpreting and applying The Children Act	25	44	Community	A & E	f/g (H) *** (C)
4.10	Interpreting and applying The Mental Health Act	3	21	*	**	***
4.11	Attending court hearings/tribunals and engagement with the Criminal Justice System	1	17	Community, Both	A & E Community areas	f/g (C) *** (H)
4.12	Attending meetings called for the purpose of child protection	9	39	Community, Both	Community areas A & E	f/g (C) *** (H)
4.13	Allocating patients/clients to diagnostic groups on the basis of which treatment is initiated	10	21	Community, Both	**	***
4.14	Facilitating group therapy meetings	3	11	Community, Both	Elderly	***
5.0	SPECIFIC NURSING SKILLS					
5.1	Adjusting patient medication in response to laboratory findings	10	30	Hospital Both	Critical Care	***
5.2	Interpreting blood results and adjusting treatment accordingly	10	31	*	Critical Care	***

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
5 3	Confirming expected death	7	28	*	Elderly	***
5 4	Prescribing drugs within protocols	10	44	Other (*)	**	***
5 5	Carrying out intubation and/or extubation	1	20	Hospital Both	Critical Care A & E	***
5 6	Managing and monitoring Central Venous Pressure lines	9	30	Hospital Both	Critical Care A & E Surgical Medical	***
5 7	Taking blood from arterial lines	4	22	Hospital	Critical Care	***
5 8	Carrying out venepuncture	31	47	*	**	***
5 9	Carrying out defibrillation	2	21	Hospital	A & E Critical Care Surgical	d/e (H) *** (C)
5 10	Inserting a peripheral intra venous cannula	7	26	Hospital	A & E Critical Care Surgical Medical Elderly	***
5 11	Initiating an IV regime within protocols	10	24	*	Critical Care Surgical	***
5 12	Administration of IV drugs	21	36	Hospital	Critical Care Surgical Medical	d/e (C) *** (H)
5 13	Running cervical cytology clinics	9	21	Community, Both	**	***
5 14	Carrying out male catheterisation	15	30	Community, Both	Elderly Community areas	d/e (C) *** (H)
5 15	Assisting with the induction of anaesthesia	4	12	Hospital	A & E Critical Care	***
5 16	Assisting the surgeon	8	15	Hospital (other)	A & E Critical Care	***
5 17	Assisting with tracheostomy formation in critical care environments	1	14	Hospital (other)	A & E Critical Care	***
5 18	Removing foreign bodies from the eye	4	16	*	A & E	***
5 19	Interpreting X-rays	2	12	Hospital (other)	Critical Care A & E	***
5 20	Undertaking breast examination	7	24	Community, Both (other)	**	h/l (C) *** (H)
5 21	Undertaking pelvic or prostate examination	1	14	Other (*)	**	***
6.0	**CLINICAL EVALUATION**					
6 1	Using computer held data to inform the evaluation of client care outcomes	21	35	Community (Other)	Community areas Critical Care A & E	***
6 2	Undertaking evaluation strategies with the use of audit tools	24	39	Community (Other)	**	f/g (C) *** (H)
6 3	Accessing local databases held on computer	17	37	Community (Other)	**	f/g (H) *** (C)

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
6 4	Accessing national databases held on computer	2	19	Community, Both (other)	**	d/e (H) *** (C)
6 5	Planning systems of nursing activity which satisfy agreed standards at local, unit or district level	30	45	Hospital Community	**	***
6 6	Evaluating quality improvements to assure the on-going quality of nursing services	31	51	*	**	h/i (C) *** (H)
6 7	Participating in multi-disciplinary clinical audit	13	38	*	**	h/i (C) f/g (H)
7.0	MULTI-DISCIPLINARY WORKING					
7 1	Actively participating in multi-disciplinary team meetings	39	60	Community, Both (other)	Elderly Medical	f/g (C) *** (H)
7 2	Actively working with social workers	33	51	*	?	***
7 3	Actively working with occupational therapists	19	35	*	Elderly Medical	d/e (C) *** (H)
7 4	Actively working with chiropodist/podiatrists	8	23	Community, Both (other)	Elderly Medical	***
7 5	Actively working with dieticians	27	43	*	Medical Surgical Critical Care	h/i (C) *** (H)
7 6	Actively working with consultants	38	48	Hospital	A & E Medical Surgical Critical Care	f/g (C) h/i (H)
7 7	Actively working with psychologists	5	25	*	Medical Surgical	***
7 8	Actively working with GPs	49	63	Community, Both (other)	Community areas	***
7 9	Actively working with pharmacists	37	45	Hospital	**	***
7 10	Participating in meetings in which decisions are made regarding selection of key workers	17	34	Community	Community areas Elderly	***
7 11	Co-ordinating the multi-disciplinary team in discharge planning	21	39	Hospital	Surgical Elderly Medical A & E	***
7 12	Participating in multi-disciplinary standard setting	14	41	*	**	f/g (H) *** (C)
7 13	Participating in the writing of shared protocols for care	16	45	*	**	f/g (H) *** (C)
7 14	Collaborating with the multi-disciplinary team in reaching clinical decisions in ethically challenging situations	7	40	Hospital (other)	Elderly Medical Surgical Critical Care	***
7 15	Contributing to shared multi-disciplinary team patient notes/records	38	50	*	**	***

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
7 16	Actively working with physiotherapists	24	36	Hospital Both	Surgical Elderly Medical Critical Care	***
7 17	Actively working with speech therapists	15	28	*	Elderly	***
7 18	Actively working with audiologists	9	21	Community, Both	Elderly Community areas Critical Care Surgical	h/i (C) *** (H)
7 19	Actively working with operating department assistants (ODAs)	10	13	Hospital Both	A & E Surgical	***
8.0	**RESEARCH**					
8 1	Identifying researchable problems	11	41	Hospital Community	**	***
8 2	Writing or collaborating in writing a research proposal	3	28	*	**	***
8 3	Communicating research findings to staff through formal and informal processes	12	39	*	**	h/i (C) f/g (H)
8 4	Effecting change based on research findings	14	51	*	**	h/i (C) *** (H)
8 5	Critically analysing the findings of research studies	11	41	*	**	h/i (C) *** (H)
9.0	**PERSONAL & PROFESSIONAL DEVELOPMENT**					
9 1	Completing reflective diaries	21	44	Community, Both	**	***
9 2	Maintaining a personal and professional portfolio	38	21	*	**	f/g (C) *** (H)
10.0	**EDUCATION**					
10 1	Undertaking informal health education activities with individuals	63	68	Community, Both	**	f/g (C) *** (H)
10 2	Undertaking informal health education activities with families and carers	48	63	Community, Both	Community areas Elderly	f/g (C) *** (H)
10 3	Operating as a mentor for students and staff	46	67	Hospital Both	A & E Medical Surgical Critical Care	***
10 4	Assessing National Vocational Qualifications (NVQ) competencies	12	29	Hospital Both	A & E Elderly Medical Surgical	***
10 5	Assessing student nurses	26	50	*	Surgical Medical A & E Elderly	h/i (C) d/e (H)
10 6	Participating in a process of clinical supervision	38	54	Hospital Both	Surgical Critical Care A & E Elderly	h/i (C) *** (H)
10 7	Disseminating information about educational resources and opportunities	25	44	Hospital	All except Community areas	h/i (C) f/g (H)

	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
10.8	Delivering formal health education activities/programmes to individuals	30	49	Community, Both	**	h/i (C) *** (H)
10.9	Delivering formal health education activities/programmes to families	20	42	Community, Both	Elderly Community areas Medical A & E Critical Care	h/i (C) *** (H)
10.10	Supporting junior medical colleagues	28	42	Hospital	All except Community areas	f/g (H) *** (C)
10.11	Educating patients/clients/carers in the use of equipment in community settings	26	43	Community	Elderly Community areas	d/e (C) *** (H)
11.0	MANAGING CHANGE					
11.1	Contributing to meetings regarding the business strategy of the Trust	5	25	*	**	h/i (H &C)
11.2	Contributing to meetings at which broad professional issues are discussed	11	41	Community, Both	**	h/i (H &C)
11.3	Formally presenting a case for change	5	35	*	**	f/g (H) *** (C)
12.0	MANAGEMENT					
12.1	Reviewing workload priorities as a response to changing contexts	47	55	Community	**	f/g (H &C)
12.2	Monitoring the actions of others to whom responsibility for patient/client care has been delegated	44	55	Hospital	**	f/g (H) *** (C)
12.3	Managing the allocation of patients/clients to a multi-skilled team	39	51	Hospital	Elderly Community areas	***
12.4	Managing care within the context of change	43	57	*	**	h/i (C) *** (H)
12.5	Dealing with formal requests for information from organisations outside the National Health Service	13	24	Community Hospital Both	**	h/i (H) *** (C)
12.6	Chairing meetings	4	14	*	**	h/i (C) f/g (H)
12.7	Inputting data to computerised information management systems	28	31	Community, Both	Community areas Elderly Critical Care	***
12.8	Managing a budget	4	28	Hospital Both	Elderly Surgical A & E Critical Care	f/g (H) *** (C)
12.9	Managing personnel issues and policies	18	33	*	A & E Surgical Elderly Critical Care	f/g (H) *** (C)
12.10	Negotiating a care package for individual patients/clients	35	54	*	Elderly Community areas Surgical	***
12.11	Taking the final decision to discharge patients/clients within defined protocols	28	41	*	All except A & E	***

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	ELEMENT OF COMPETENCE	CRUC C	CRUC P	SETTING	AREA	GRADE
12 12	Writing discharge letters to GPs	10	23	Hospital Both	Elderly Surgical A & E Critical Care	***
12 13	Managing nurse led clinics	30	48	Community, Both	Community areas	l/g (C) *** (H)
12 14	Initiating and maintaining the use of patient/client held records	55	59	Community, Both	Community areas Elderly	***
13.0	COMMUNICATION					
13 1	Using counselling skills in dealings with clients	64	76	Community	**	***
13 2	Using counselling skills in dealings with their families	56	72	*	**	l/g (C) *** (H)
13 3	Using counselling skills in dealings with colleagues	38	66	*	**	h/i (H &C)
13 4	Dealing personally with patients, their families or carers who make a complaint	11	59	Hospital Both	**	***

Differences between Hospital and Community Practice

In addition to the map, the report presents, in appendices h and i, a list of competencies for which significant differences between hospital and community settings were demonstrated.

In the mental health sample 38% of the competencies demonstrated a significant difference between settings. This contrasts with the adult sample where a significant difference of 68% was found between settings. It could therefore be argued that the skills of the mental health nurse are, to a degree, more transferable than those of their adult branch counterparts. The alternative explanation is that the adult branch survey tool was inherently more accurate in picking up the subtle skill differences within community or hospital environments. It is hoped, however, that this risk was minimised by the expert panel validation and the fact that the statements were inductively generated.

Ranking of the Competencies

The competence statements were subsequently ranked according to their cruciality now and for the future. These ranking tables are presented in appendix j (mental health, current), k (mental health, predicted), l (adult, current) and m (adult, predicted).

The statement ranked 1 is that which the greatest number of respondents claimed either to demonstrate regularly or which they believed would be vital for the future.

Adult Sample - Rankings

A study of the "Top 20" statements ranked in terms of current and future cruciality reveals that for the adult sample, there is no change in the first position. *"Undertaking comprehensive health needs assessment of individuals"* is currently the most regularly seen competence and is also rated most important for the future. A comparison between the current and future rankings reveals three new competencies in the future "Top 20" chart. Currently 39% of practitioners recorded that they regularly "*actively participated in multidisciplinary team meetings*" but 60% believed that this would be important for their role in the future - a rise in the ranking from 24th to 14th. *"Using counselling skills in dealings with colleagues"* rose from 29th (38% of respondents reporting that they did this regularly) to 9th (66% believing it important for the future). This is consistent with the development of models for clinical supervision. By far the greatest leap in terms of ranking was seen in relation to the statement *"Dealing personally with patient/carers who make a complaint.* This rose from a position of 79th (11% of respondents) currently to 16th (59% of respondents) for the future. It is not clear whether this represented an expectation that the incidence of complaints would rise or whether nurses believed that they would be empowered to deal with them rather than expected to pass up the management line.

Mental Health Sample Rankings

Repeating the process described above in relation to the mental health sample, it can be seen that the first four competency statements in the ranked mental health set were retained when considering their importance for the future. Further study reveals that there are 6 new competencies in the future "Top 20" chart. *"Assessing anticipating and diffusing aggression,"* which is currently ranked 26th (52% practitioners doing it regularly), is predicted to rise in importance to 5th (79% perceiving it to be important for their role in the future). *"Interpreting and applying the Mental Health Act"* rose in rank from 25th to 10th (53% to 71%); *assessing student nurses* rose from 34th to 12th; *monitoring the actions of others to whom patient care has been delegated* rose from 21st to 14th. *Making and acting upon decisions which carry risks to clients* from 28th to 15th and *participating in a process of clinical supervision* rose from 29th to 16th.

Pre or Post Registration Outcome?

The final columns in appendices k and m indicate the percentage of respondents who believed that the competency statement in question should be an outcome of pre-registration education. Significant differences were noted between the adult and mental health samples in relation to the core competencies tested. Examples are given below.

Table 11 Examples of Significant Differences between Adult and Mental Health Samples for Pre Registration Core Outcomes

No	Competence	% of adult resps selecting pre-reg	% of MH resps selecting pre-reg
2.1	Fostering autonomy of clients in relation to health care decisions	53	80
2.4	Acting as a patient/client advocate regarding quality of life issues	38	63
7.2	Actively working with social workers	46	78
10.6	Participating in Clinical Supervision	14	29
12.4	Managing care within the context of change	28	41

Mental Health respondents were significantly more likely to designate activities as proper outcomes of pre-registration than were adult respondents. Indeed, of the adult sample only 16 of the 121 statements (13.2%) were deemed pre-registration outcomes by half or more of the respondents. This contrasts with 45 of the 107 mental health competencies (42%). Mental Health practitioners thought that an outcome of pre-registration education should be competence in all areas relating to working with the multidisciplinary team other than in relation to the *"development of shared protocols of care,"* and *"actively working with probation officers"* which fewer than half thought were appropriate. A majority of the adult sample indicated that **none** of the multidisciplinary competencies were appropriate for pre-

registration students other than actively working with dieticians (51%) and physiotherapists (50%).

A surprising finding in the current climate was that "*managing care in the context of change*" was indicated by a minority of both samples to be a pre-registration outcome. This apparently conservative approach to what students preparing for parts 12 and 13 of the Register should be achieving may alert educationalists to review the expectations of qualified nurses who supervise and assess students. Overall, there appeared to be differences between the views of managers qualitatively gathered and those of D to I grade nurses collected within the survey; with the latter indicating that competencies currently addressed in post -registration programmes should continue to be achieved at that level. A comparison of these groups was not amongst the purposes of the survey, although in view of the apparent disparity of expectations, statistical evidence would have been valuable..

Discussion of the Competency Map in Relation to the Qualitative Findings

It must firstly be borne in mind that the survey, like the focus groups is offered in counterpoint to that of the interviews which were heavily biased towards the medium to long term view of senior and middle managers. The survey sought to gather the responses of practitioners with whom pre-registration student nurses are likely to be placed in order to make placement recommendations. Differences between the findings must therefore be interpreted in this light.

Secondly, it is necessary to repeat the earlier caveat that because of the relatively small size of the sample, caution should be exercised in the interpretation of the results. In order to apply statistical tests to the areas of practice and grade categories had to be condensed. Thirdly it must be remembered that the study did not test a complete set of nursing competencies but only those which were a development of or change to the role of the nurse and those said by earlier respondents to differentiate hospital / residential and community based practice.

Given the latter statement, the most immediately striking feature of the results is the relative dearth of significant differences between areas of practice, care settings and nurse grades in relation to the elements of competence tested. In the **mental health** sample it was found that 62% of the competency statements showed no significant difference between hospital, community or combined posts. Similar pictures emerged in relation to area of practice where 69% of the statements showed no significant difference and in respect of grade where 44% of the statements had no significant differences attached. The picture was slightly more defined in relation to **adult** nursing but even here the figures suggest that a sizeable number of the statements were not affected by setting (32%), area of practice (40%) or grade (53%.)

Whilst these results might suggest a high proportion of the competency statements are not dependent on specific placements, such a judgement would be ill-founded without examining the nature of those statements for which significant differences between setting, area of practice and nurse grades, have been demonstrated. These differences are set out below, under the following headings.

Core Competencies in adult and mental health nursing practice

- Managing and influencing change
- Relationships between service providers
- Monitoring and Managing quality
- Health and social needs assessment:
- Advocacy
- Clinical supervision
- The shift to an evidence base
- Professional development and professional portfolios:
- The role of Management

The Mental Health Sample

- Care in the community
- Risk assessment and management
- Care management and negotiation:
- Forensic nursing

The Adult Sample

- Increasing efficiency in the in-patient period
- Care in community settings
- The reduction in junior hospital doctor's hours
- Admission and discharge decisions

Managing and Influencing Change

Significant differences between hospital/residential and community settings were demonstrated in relation to the following statements:

11.1 Contributing to meetings regarding the business strategy of the trust
11.2 Contributing to meetings at which broad professional issues are discussed
11.3 Formally presenting a case for change
12.4 Managing care within the context of change

Of the above competencies relating to the change agenda, three can be considered proactive in character in that they offer nurses the opportunity to raise issues and exert influence. The fourth implies a more reactive approach. In the adult sample all four statements rose in their rankings of importance in the future. In the mental health sample, whilst the fourth statement rose in respect of its predicted importance for the future (predicted cruciality) it fell in rank. This may suggest either a conscious rejection of such management in the future or an expectation of a future period of relative stability in which less major change will occur. A third explanation is simply that other elements of competence were seen as of a higher priority.

Relationships between Service Providers

Changing relationships with GPs, the independent sector, and social services were highlighted in chapter 3. The survey included three competencies which sought to address these issues:

7.8 actively working with GPs
1.3 working in conjunction with the voluntary and private sectors
7.2 actively working with social workers

In the mental health sample, only the first of these statements rose in relative importance. Currently 41% of the mental health sample worked regularly with GPs but 56% (a positive change of 15%) regarded it as vital to their future role. The changes predicted for the other two statements were less marked, with a percentage change of only 2% in relation to working with social workers and 5% for the independent (voluntary and private) sectors. This suggests that of these three elements nurses see GPs as having the most impact on their future role within the specialist mental health service. This would seem to be consistent with the Government's stated intentions to develop further the functions and roles of the primary health care team as the 'jewel in the crown' of the NHS. It also reinforces the views of managers concerning the major impact of fundholding and the increasing influence of GPs for the future.

Within the adult sample a similar picture emerged in relation to working with GPs. This competence showed both an increase in ranking and a 14% increase in cruciality (from 49% to 63%). However, in the adult sample the importance of working with social workers

was also highlighted. The increase in this case was 18% (from 33% to 51%) and its ranking relative to other competencies also rose.

The adult sample revealed a relative drop in importance (-3%) attached to working in conjunction with the voluntary and private sectors in the future (from 28% to 25% and rank from 46 to 90). The reason for this finding is not clear and it certainly appears to be at odds with the findings of the qualitative study where it is clear that the independent sector's influence is recognised (p 45). However, as pointed out above, the key difference between the quantitative and qualitative samples was that managers were, by and large, excluded from the quantitative work. Certainly, this drop in cruciality was not a feature of the mental health sample, suggesting differences between the two areas in relation to the importance attached to the voluntary and private sectors.

Monitoring and Managing Quality

Several of the competencies dealt with skills that are an integral part of any quality management system. The qualitative study emphasised the increasing assimilation into the nursing role of mechanisms for increasing efficiency and the use of technology (p 48). These characteristics, particularly the use of [information] technology are features, not just of nursing, but of the post-Fordist development of organisations generally (Zuboss, 1989). Consequently four of the core skills addressed by the survey instrument are:

12.7 inputting data to computerised information management systems
6.1 using computer held data to inform the evaluation of client care outcomes
6.6 evaluating quality improvements to assure the on-going quality of nursing services
6.2 undertaking evaluation strategies with the use of audit tools'.

For the mental health sample, with the exception of 6.1, each of these competency statements saw their cruciality rise in the future. This suggests that nurses are generally aware of the impact of technology and the importance of linking quality data and information management as part of their future role. Further, the results suggest little difference between care settings in relation to the regularity of quality-based skills with the exception of *'inputting data to computerised information management systems"* which is a more regular activity for community nurses.

For the adult sample the picture was similar except that it was statement 6.6 which rose in relative importance for the future - with over half of the sample seeing it as vital to their future role. With the exception of 6.6 these competencies are all associated most strongly with community-based work. The lack of evidence to support a hypothesis of difference between settings in relation to this one exception is perhaps unsurprising given the largely vague and subjective nature of quality as a concept. This point is recognised by commentators such as Harrison and Pollit (1994) who point to the multiple meanings underpinning quality currently being operationalised in services.

Health and Social Needs Assessment

Of the nine survey statements which explicitly sought to look at health and social needs, four were ranked in the top 15 in terms of current cruciality (3.1, 3.4, 3.7, 3.8) in both samples.

3.1 **Undertaking comprehensive health care needs assessment of individuals**
3.2 Undertaking comprehensive health care needs assessment of families
3.3 Undertaking comprehensive health care needs assessment of communities
3.4 **Assessing social/life skills**
3.5 Assessing neurological function
3.6 Taking the final decision to admit patients/clients to hospital within protocol criteria
3.7 **Making a daily assessment of all clients for whom I am responsible**
3.8 **Recognising the effects of prescribed drugs and drug interactions**
3.9 **Carrying out physical assessment of patients/clients**

Within the mental health sample, the majority of these competencies did not demonstrate a significant difference by care-setting. Of those that did, hospital settings appeared to offer the best opportunities for *"Making a daily assessment of all clients for whom I am responsible"*.

Within the adult sample the five statements which are undertaken by more than 50% of nurses on a regular basis are highlighted. Again amongst adult nurses it is interesting that competencies 3.1 and 3.2 are primarily a feature of community-based f/g grade nurses. Indeed these two competencies alone are most associated with community settings. Hospital/combined environments provide the optimal locations for three of these competencies (3.7, 3.8, 3.9), whilst 3.5 was most closely associated with hospital environments.

Advocacy

The issue of advocacy is addressed by the inclusion in the survey of the competence:

2.4 'acting as patient/client advocate regarding quality of life issues'.

The survey suggests that it is in mental health nursing that the opportunity to observe such practice is most widespread. More than half (52%) of this sample stated that they regularly assumed the role of advocate as opposed to 42% of adult branch nurses. However, the current-predicted percentage increase (adult 14%, mental health 5%) suggests that the advocacy role is gaining in importance within the adult nursing. It comes as little surprise that a skill which embodies such an important core value within nursing culture generally appears not to differ significantly between care settings, areas of practice or nurse grade in either of the samples.

Clinical Supervision

Issues of quality, professional standards and accountability are, theoretically at least, addressed by clinical supervision. Despite the cautious tone of the respondents in the qualitative study (p 51) the results of the survey suggest that this is a widespread feature of both mental health and adult branch nursing practice (50% of mental health and 38% of adult nurses take part regularly). More importantly its relative importance for the future within both samples rose and more than half of both samples saw it as vital to their future role. As for selecting the sites that provide the best opportunity for observing the process, no significant differences emerged within the mental health sample. However, in the adult sample the best opportunities were afforded by placements in surgical services, critical care, A&E/acute admission or elderly care areas. This raises some concerns for the deployment of newly qualified nurses in the community. It is not clear why only 14% of adult and 29% of mental health respondents were of the opinion that *'participating in clinical supervision'* should be an outcome of pre-registration education (table 11).

The Shift to an Evidence Base

Skills alone are only part of the equation for the future role and 'competence' of the nurse. An accountable practitioner is also required to relate these to research findings and, perhaps more importantly, to change practices when research indicates that interventions are ineffective or inappropriate. The survey included five competencies which explicitly dealt with research and evidence based practice:

8.1 identifying researchable problems
8.2 writing or collaborating in writing a research proposal
8.3 communicating research findings to staff through formal and informal processes
8.4 effecting change based on research findings
8.5 critically analysing the findings of research studies

Some of the biggest shifts in both relative and absolute cruciality were demonstrated in these competencies, indeed in the adult sample all the above competencies tripled in the future. These results add impetus to the stated need to increase the research skills and awareness within the profession. Given that 8.3 and 8.4, the most commonly undertaken of the research competencies in the mental health and adult samples respectively, were a regular feature of only 11% and 14% of nurses' work, any assumptions that the profession is already moving towards evidence based practice would be ill-founded. Moreover, the lack of research-based training opportunities appeared to exist across settings and areas of practice. However, the fact that so many nurses recognise the importance of these skills for their future role must lend an air of optimism to those commentators who argue that the profession is ready to accept research as a basis for practice.

Professional Development and Professional Portfolios

One final point regarding the competencies examined in the survey concerns the issue of maintaining a personal and professional portfolio as part of on-going professional development. Within the adult sample this one competence demonstrated the greatest fall in relative importance for the future (from a current ranking of 27 to a ranking in terms of future importance of 102). More alarmingly, its absolute importance for adult nurses also dropped from 38% of nurses currently completing a portfolio on a regular basis to only 21% of nurses seeing it as important for the future. Based on these findings the nurses sampled appear to be questioning the usefulness and importance of such an approach to professional development. This must cause concern to the statutory body, which has made a significant investment in educating practitioners as to the future role of the professional portfolio. It must be noted that this finding was not replicated within the mental health sample, where this competence rose in both absolute and relative importance.

The Role of Management

The following elements of the management function were included in the survey:

12.1 Reviewing workload priorities as a response to changing contexts
12.2 Monitoring the actions of others to whom responsibility for patient/client care has been delegated
12.3 Managing the allocation of patients/clients to a multi-skilled team
12.4 Managing care within the context of change
12.5 Dealing with formal requests for information from organisations outside the National Health Service
12.6 Chairing meetings
12.7 Inputting data to computerised information management systems
12.8 Managing a budget
12.9 Managing personnel issues and policies
12.10 Negotiating a care package for individual patients/clients
12.11 Taking the final decision to discharge clients within defined protocols
12.12 Writing discharge letters
12.13 Managing nurse-led clinics
12.14 Initiating and maintaining the use of patient held records

In both samples the first 13 of the above statements all rose in **absolute importance** for the future although only two (12.10 and 12.13) rose in terms of **comparative ranking** in both adult and mental health samples. As with all the above, the optimum settings and placement areas in which these competencies can be achieved are set out in the map (tables 9 and 10)

The Mental Health Sample

Care in the Community

Chapter 4 highlights the shift from hospital to community-based care and recognises the changes required in the nursing role if the policy is to make further progress **(pp 59-61).** At least five of the competencies included in the survey were intended to reflect this changing context:

1.1 Having patient contact in both hospital and community settings
1.4 Negotiating and retaining access to patient's/client's homes
1.5 Undertaking nursing practice in settings physically remote from colleagues
4.6 Administering and disposing of medicines (including controlled drugs) outside the hospital situation
4.8 Interpreting and applying the Community Care Act

The evidence from the survey suggests that while mental health nurses generally see absolute increases in the future importance of these competencies (except for 1.5) their ranked importance is not so assured. Only two of these competencies (4.6 and 4.8) demonstrate this increase. Not surprisingly, with the exception of 4.8, the competencies all appear to be most frequently developed in community/combined settings and in the cases of 1.1, 1.4 and 4.6 in the higher clinical grades of F/G.

Risk Assessment and Management

The qualitative section of the report highlights the '... considerable interest in developing skills related to increasing the predictive validity of such [risk] assessments' (p 60). The results of the survey suggest that mental health nurses all recognise the growing importance of this element of the nurses role in the future. There were four 'risk assessment' competencies included in the survey.

4.1 Making and acting upon decisions which carry risks to patients/clients
4.2 Making and acting upon decisions which carry risks to families
4.3 Making and acting upon decisions which carry risks to communities
4.4 Making and acting upon decisions which carry risks to the organisation

Each of these saw their relative importance rise considerably with, for example, 68% of respondents seeing 4.1 as important for their future role.

The results suggest that levels of nurse contact with decisions of this type are currently spread across most settings, areas of practice and grade. The primary exception is revealed as "*making decisions with risks for families*," which is most regularly demonstrated in community settings. On a more specific note, the report identifies '*taking the final decision to discharge clients*' (ibid) as a focal point for changes relating to risk. The quantitative picture for 3.6 is one of a slight increase in relative importance (from current rank 46 to predicted importance rank of 44). The areas most closely associated with current demonstration of this competence appear to be in community settings and in this case are a feature of the higher grades of the nursing hierarchy (H/I).

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Care Management and Negotiation

Reducing the probability of occurrence of adverse events is a key objective of effective care management. Since the implementation of the NHS and Community Care Act the ability to plan a coherent and cohesive multidisciplinary package of care has been a key competence of mental health nurses. The three primary competencies which embody care management are:

7.11 Co-ordinating the multi-disciplinary team in discharge planning
7.17 Collaborating with the multi-disciplinary team in delivery of the care programme approach
12.10 Negotiating a care package for individual patients/clients

Analysis of the findings reveal that these competencies all remain static or gain in relative importance in the future; with well over half of the respondents (and almost two thirds, in the case of 12.10) viewing the skills as vital for their future role. There appears to be no single optimal location or nurse grade group which can act as a demonstration site.

Forensic Nursing

The report thus far has acknowledged the view of managers who perceive forensic psychiatry as of increasing importance in the future (p 63). Not surprisingly the 'map' suggests that forensic environments provide the optimum location for observation of the skills needed to work with such clients. The raw Kruskall-Wallis matrices for the competencies addressing this recommendation - *'contributing to the care of clients who are undertaking custodial sentences/subject to probation orders'* - show the very low mean rank for forensic environments generally when compared to other areas. Therefore specialist experience in prisons, with police and with the probation service may be necessary to provide experience of this type in the future.

The Adult Sample

Increasing Efficiency in the In-patient Period

The qualitative data reveals that several changes were occurring in adult nursing as a result of the emphasis on increasing levels of efficiency within provider units. More specifically, the report details the development of nurse-led clinics and shared protocols for care as two of the mechanisms occurring at service level and highlights some degree of conflict between managers and practitioners (pp 72-73). The survey reveals that nurses attach increasing importance to these areas of competence in the future. Whilst only 16% of nurses currently participate in the writing of shared protocols and less than a third manage nurse-led clinics (30%), almost half of the sample see these two skills as important for their future role. No one area or setting provides the optimum location for observing shared care protocols. However, the results do highlight the fact that community/combined locations and areas of practice have a significantly higher level of nurse managed clinics than other areas

On the basis of this it is reasonable to suggest that community nurses are currently in the vanguard of such skill development.

Care in Community Settings

1.1 Having patient/client contact in both hospital and community settings
1.4 Negotiating and retaining access to patients'/clients' homes
1.5 undertaking nursing practice in settings physically remote from colleagues

Chapter four highlights the changing nature of hospital based work in the face of developments in the primary-tertiary interface. More specifically, it refers to the development of outreach services and the continuity of client contact that accompany this new role **(pp 83-84).** It also identifies the expressed fears of nurses who are required to adjust to working at a physical distance from colleagues.

The survey data show that these three skills are not the sole preserve of community nurses. 5% of hospital based nurses claimed to demonstrate these competencies on a regular basis.

The Reduction in Junior Hospital Doctors' Hours

The report cites the influence of 'A New Deal' (DoH 1991) and the consequent reduction of the hours of junior doctors hours as one of the more powerful change agents in relation to adult nursing (p88). More specifically, the report highlights four particularly prominent skills which the profession is assimilating in some parts of the country:

5.4 Prescribing drugs within protocols (10%; 44%)
5.8 Venepuncture (31%; 47%)
5.12 Intra-venous administration of drugs (21%;36%)
5.10 Insertion of peripheral Intra-venous cannula (7%; 26%)
5.14 Urinary catheterisation of male as well as female patients (15%; 30%

(The numbers in brackets indicate the percentage of practitioners reporting that they currently demonstrate this competence regularly, and the percentage reporting that it would be vital for their role in the future). Respondents in the survey consistently demonstrated an expectation that these skills would be increasingly important for their future role. It is clear that the majority were expected to assume greater importance for the nurse's role in the future. Of these, drug prescribing was especially valued. The absolute increase shown for this competency statement rose by 34% (from 10% of nurses of nurses currently prescribing regularly to 44% who see prescribing as vital to their future role.

It might be argued that many of these competencies are associated with specific environments and to some extent the findings support this hypothesis. But equally many of the skills show no significant difference either between care setting or area of practice. Appendix i shows the settings which are most closely associated with observation of these competencies. In terms of areas of practice in which to observe these skills it appears that

A&E/acute admission and critical care areas have a particular role to play in fostering these skills. However, to suggest that such high technology environments are the only places to offer access to learning opportunities would be misleading. At least 5 of the competencies presented here are also linked to surgical areas (5.6, 5.9, 5.10, 5.11, 5.12). These results suggest a potential growth in the skills base of nurses and a recognition of the spread of the nursing role into areas of practice that have traditionally been the preserve of the junior doctor.

Admission and Discharge Decisions

3.6 taking the final decision to admit patients within defined protocols
12.11 taking the final decision to discharge patients within defined protocols

The report highlights the growth of admission and discharge protocols in adult nursing (p 80). The picture emerging from the survey results suggests that whilst nurses see an absolute increase in the importance of these two competencies for their future role, their importance relative to the other 121 skills presented is reduced. The reason for this is not clear. It might reasonably be assumed that the greater autonomy suggested by these skills would be welcomed by the profession. Perhaps the key lies in the recognition that there are two sides to this particular coin. With autonomy comes the need for accountability, and in the context of a multi-disciplinary approach to service provision, the need to be assertive (p 81).

There were no significant differences between care settings in relation to these two competencies nor between the nurse grade groups sampled. It is interesting to note, however, that nurses are more likely to discharge than admit patients. Only 6% of nurses currently admit patients as opposed to the 28% who discharge patients on a regular basis. In this arena medical control remains the predominant norm.

The study was designed to identify the current and predicted changes in nursing competencies required to deliver care to patients and clients in hospital and community settings, and to inform the Board of the optimum practice placements in which these can be achieved by students preparing for parts 12 and 13 of the Register.

"Change", remarked Charles Handy, "is not what it used to be" (Handy, 1989). Even within the NHS, where organisational change appears to be the norm, its pace and extent since the inception of the reforms has been remarkable. Perhaps the first recommendation of this report should be that any aspirant to the profession should be enabled to see structures as dynamic entities in, at best, temporary equilibrium and to recognise within any change agenda opportunities to influence the future. This accords with the view of the ENB expressed in "Creating Lifelong Learners" that as a result of their pre-registration education, nurses should be not only flexible and adaptable but "able to work as change agents." (ENB 1994, p6)

In such a changing and challenging world it might be expected that education would be a high priority and so it proved to the respondents in the study. However, there were clearly stated requirements that educationalists should, in the words of the Statement of Strategic Intent (DoH 1994f):

> "... achieve relevance; ... create and maximise opportunities for shared learning; ... within a framework that is explicitly practice led, research based and employment focused; and to devise and explore new and potentially more effective modes of delivery." (DoH 1994f, p11)

When discussing the educational implications of the developments envisaged in service delivery, managers frequently failed to specify whether a given competence should be addressed at pre- or post- registration level. When challenged, more often than not the reply was "both, simultaneously." The changing world for which currently qualified nurses have to be fitted is the same world for which students have to be prepared. Responsive education must produce Registered Nurses who are 'fit for purpose; fit for practice' - ready, in contemporary jargon, to "hit the ground running." It became apparent that no questions were to be left unasked in the search for the ideal practitioner.

Conventional training programmes distinguished between experience and skills seen as relevant to the hospital setting and those addressed 'in the community'. Empirical evidence for this differentiation was not always present and consequently aims and objectives were often vague in nature and not particularly suitable for development as learning outcomes. The demonstration of these are a key feature of any approach to competence which acknowledges the conceptual heritage underpinning the term. In recent years the

development of practice nursing and outreach services have emphasised the significance of broader policy contexts in determining the current and future functional requirements for the profession. Moreover, within the study there was evidence of a growing trend to appoint D (6% of total community nurse respondents for both adult and mental health) and E grade staff nurses (29% of adult and 38% of mental health) to community posts and comparisons were being made between the competencies displayed by these nurses and those of the specialist practitioner who heads the team. There is a view expressed by some managers that the Diploma course should substantially equip practitioners with the majority of the competencies traditionally addressed in community programmes (and set out in the guidelines published with "Creating Lifelong Learners" (ENB 1995b). There were, however, some apparent reservations amongst adult nursing managers who acknowledged that the professional autonomy and lack of peer and medical support which is the hallmark of working in a community setting is normally better managed by experienced, rather than newly qualified, nurses. In relation to mental health, however, with the majority of service users now in the community, it was clear that fitness for purpose at the point of qualification should indeed include an ability to give competent care in community settings. The Butterworth report, (DoH, 1994a) notes:

> "Project 2000 seeks to prepare people to work in all settings. Nonetheless there is evidence that newly qualified nurses are encouraged to work within an institution before moving into the community. Such practice will not test whether the new programme adequately prepares students to work safely in community settings." (p42)

As outreach services develop, and managers take the aspirations of Project 2000 literally there is an urgent need for research to establish the degree of competence shown by newly qualified nurses working in community settings.

Yet it was acknowledged that there were challenges inherent in developing such a flexible practitioner. Placements in community settings are relatively few and are highly sought after. With supervision levels at 1:1, the situation is one of quality with scarcity. From the evidence gathered within the 21 focus groups the key competencies which appeared to differentiate between hospital and community practice were identified. Of the 107 mental health competencies tested in the survey it was found that 62% showed no significant difference in frequency between hospital, community or combined-based posts. The picture was slightly more defined in relation to adult nursing where, of the 121 competencies tested, it emerged that 32% of the statements were not affected by setting.

Whilst it was not raised by respondents within the study, the findings do raise questions about the management of the community care agenda within pre-registration education, particularly in relation to the adult branch. Given the increasing specialisation of care in client's homes it can be argued that all specialist nursing education should relate both to hospital and to community settings. There are pertinent questions to be asked in relation to the ability of

many nurse teachers to discuss community aspects of care within their own specialist field. As outreach services develop, teachers should take opportunities to gain experience in client care in the home. It can be argued that it is no longer acceptable for community expertise to be vested solely in a small number of "community tutors."

Inevitably, there was considerable debate around the development of a flexible and collaborative framework in the interface between health and social care. The emergence of a strong and vocal body of GP Fundholders as purchasers of health care was challenging a host of long held assumptions about the delivery and management of care. Many respondents made reference to the need for all nurses to be aware of the whole range of community services available to support the patient and the family at home. Whilst it was recognised that a comprehensive working knowledge of such systems might not be feasible at pre-registration level, it was agreed that all nurses must be aware of the main services available and demonstrate ability to access these on the client's behalf.

Concerns were expressed by managers and educators alike about skills developmen in both adult and mental health branches. This was variously attributed to:

- the reduction in exposure to practice in the Diploma programme as compared with traditional nurse training
- the time available for teaching in the practice setting where skill mix reviews have resulted in a reduction in qualified staff;
- reduced numbers of teachers with increasing workloads who are less available to teach in practice settings

Colleges in the study were considering setting up skills laboratories according to the Maastricht model (Schmidt et al, 1986) partially to address this issue. Such facilities allow students decontextualised practice (be it of counselling, control and restraint or venepuncture), and promise a baseline standard with which they go equipped into clinical areas. The principle of not learning "clutch control on the High Street" (Nicklin & Lankshear, 1994 p 87) appears to be a reasonable one. All recognise, however, that transferring such learning to a real world context is a process which requires careful management.

Additionally, there were complaints from managers in both mental health and adult nursing services that Project 2000 graduates lacked basic managerial skills. Specific areas of weakness mentioned by respondents included the confidence to draw up a care plan, manage care in practice, and to undertake practical managerial tasks such as the development of a duty roster.

In relation to the above, it is germane to note that the term 'supernumerary status' appears to be obstructing precisely what the concept was designed to facilitate. There is evidence that some students are seeking to differentiate their status on clinical areas by refusing to

participate in some aspects of patient and client care. Whilst this was not a widespread concern, it re-affirms previous findings (Orton 1993; Jowett et al, 1994) and is thus a cause for concern. It can be argued that the battle for supernumerary status was won at the point at which central government funding was secured for replacement staff. Now that Diploma courses are fully established it may be merely confusing for students to be told that they are supernumerary and it may imply that they should in some way be behaving differently from other staff in placement areas. Students need to know only that they, like their counterparts in teaching and social work, are students, and not employees of the trusts or other agencies with whom they are placed.

Mental Health Nursing

In the field of mental health a number of key issues were raised. Whilst "being with" users of the service (Paterson and Zderad, 1976) is acknowledged to be of key importance there was a recognition that the profession had to learn to value and to articulate the therapeutic nature of nursing interventions (McMahon and Pearson, 1993). Mental health nursing services are not immune from the general requirement to move to an evidence base where effectiveness is judged in terms of clearly defined outcomes. Within the literature review Carpenter and Turnbull (1991) promote the "being" qualities of the mental health nurse, arguing that these are more important than the "practical physical aspects of care". Whilst the primary importance of relationships in this branch of nursing is of course fully recognised, evidence from the study suggests that it is the nurse's understanding of the physical *and* psycho-social needs of users which sets the nurse apart from other professionals. In a world of financial constraints, where, as health visitors have found, "soft" skills are 'soft targets' mental health nurses should be aware that the understanding of the physical health needs of clients *in association with* the spiritual and psycho-social is highly valued both by nurse managers and by practitioners in other agencies. The responsibilities of nurses in respect of the administration and monitoring of drugs and their effects was a frequently mentioned discriminator between nurses and other professionals engaged in the delivery of care to users of the mental health services.

In the wake of recent violent incidents involving people with mental health problems (DHSS, 1988b; West Midlands RHA 1991; SW Thames RHA, 1994; Blom Cooper, 1995; Woodley, 1995) attention was drawn to the responsibilities of nurses in relation to risk perception, assessment and management. Whilst there is a sense in which nurses have always assessed risk, and been charged with the responsibility of communicating concepts of risk to clients, practitioners are increasingly being required to adopt a systematic approach to the assessment and management of risks to and from clients. It is axiomatic that the underpinning knowledge and skills must be addressed in pre-registration education.

In the present study concern was expressed concerning the ability of students preparing for part 13 of the Register to relate theory to practice. It was suggested by respondents that this

was related to the dilution of mental health experience within the Project 2000 programme, but no *a priori* evidence is presented within this study in support of this assertion. We commend the advice of the English National Board within its response to Working in Partnership (ENB 1995a) that educationalists should:

> "Review their teaching strategies to ensure that those providing input into the common foundation programme are able to help students to set their learning within a mental health context
>
> Ensure there is articulation between the Common Foundation Programme and the Mental Health Branch Programme and that the development of the skills of the mental health nurse commence at the outset of the programme" (p 5)

Adult Nursing

The proportion of day surgery in relation to all elective surgery is set to rise to 60% in the year 1997-98 (NHSE (94)55 1994e). It is essential that pre-registration adult students should recognise the importance of pre-assessment and the giving of accurate and timely information in this context. Within inpatient settings, the drive for increased efficiency, coupled with the demands of "A New Deal" (DoH 1991b) has led to nurses taking a greater co-ordinating role. As part of the admission procedure in some areas, nurses are acting in accordance with locally devised care protocols ordering appropriate investigations and, in some places, initiating treatments in advance of a medical assessment. (10% of respondents in the survey claimed to be initiating IV regimes or prescribing medications within protocols with 23% and 44% respectively believing it to be vital or important for their role in the future). It follows that a thorough grounding in physiology and pharmacology are required at pre-registration level.

When nurse managers contemplated the specific and necessary skills that they require of the newly qualified staff nurse of the future they consistently listed the following:

- Venepuncture (31%; 47%)
- Intra-venous administration of drugs (21%;36%)
- Insertion of peripheral Intra-venous cannula (7%; 26%)
- Urinary catheterisation of male as well as female patients (15%; 30%

(The numbers in brackets indicate the percentage of practitioners reporting that they currently demonstrate this competence regularly, and the percentage reporting that it would be vital for their role in the future). Three of these skills were in the list of six recommended by the Greenhalgh report (Greenhalgh, 1994) for inclusion in pre-registration education. The fourth, male catheterisation, was on the list of seven activities which were said to constitute 75% of the work of junior hospital doctors (Greenhalgh, 1994, P102). It is recognised that in some parts of the country the junior doctor's agenda has been handled differently (see the SHARR Report, Read 1995.); however, the view of managers in the study was that the assumption of such work has the potential to increase significantly the quality of patient care. Nurses can capitalise on their one distinguishing feature in a hospital setting - that of 24 hour

presence - to prevent delays in instigating investigations and treatment, and also to develop a level of skill lacking in the traditional system of medical training (Ashcroft, 1992). Furthermore, these tasks require close physical contact with patients which enable the real work of nursing to be carried out simultaneously. It could be argued that these duties are a more legitimate part of the role of the nurse than many aspects of the role which take the nurse away from the bedside. The real concern of some practitioners in the focus groups was that the extra work was unresourced, and other aspects of care were being less well addressed. This was recognised by the Chief Nursing Officer for England in an early article relating the requirements of the "New Deal" to the UKCC Scope of Professional Practice (Moores 1992).

Multidisciplinary and Inter-agency Working

In relation to multidisciplinary team working, there was a general recognition that the members did not have a full and clear appreciation of one another's roles. This was said to lead to inappropriate referrals and client allocations, and to differences of opinion as to the best person to tackle an issue. This would be addressed by the utilisation of short placements in other NHS departments and in social care agencies during pre-registration education. The NHSE letter EL(95)96, with its recommendation that social services be represented in the education and training consortia, may facilitate the availability of Local Authority Social Services placements for nurses.

Nurses are perceived to suffer from a number of disadvantages in relation to their colleagues within the multidisciplinary team, and these are explored in the report. Nurses have a reputation, both within and outwith the profession to be retro-active rather than pro-active, giving background information to inform decisions rather than making specific recommendations for future treatment and care. Overall, nurses are perceived to lack self-confidence in relation to their colleagues from other professions. Other members perceive them to have a central co-ordinating function within the team, but at the same time are critical of the standard to which they perform. The profession needs to grasp the nettle of "cover" for other agencies during unsocial hours, and multi-professional discussions should inform the precise outcomes of programmes for nurses. Nurses need to be able to do what they have to do well, whilst being clear about what it is that they cannot and should not be doing on behalf of others. At pre-registration level nurses must embrace care management skills, including, where appropriate the delegation, supervision and monitoring of care and have the competencies required of a key worker in relation to disseminating information and convening review meetings.

Placements

Within the map of identified competencies (see tables 9 and 10) the optimum placements for the achievement of the competencies tested are given. It is recognised that the move to

community care has created a number of difficulties in the provision of placements. It was with regret that many of the educationalists interviewed recognised the advantages which would be conferred were they to have resources with which to purchase placements. The guidance issued by the NHSE (EL 95/96) is welcome in this respect, but does not resolve the difficulties in securing sufficient valuable experience within GP practices, for which many require payment.

This is but one aspect of commissioning that the new Education and Training Consortia will address when they become operational in April 1996. Their role however embraces a wider agenda than just nursing. The needs and demands for nursing staff will be placed within the context of the needs and demands for other professions. Many of the issues identified in this project are not new. What is new however is this broader remit for the commissioning of non medical education and training and the implications this has for deciding the allocation of practice placements.

The challenge, and responsibility, for both commissioners and providers is to ensure that decisions about placements are made not solely on the basis of short term expediency but with an awareness of the long term impact upon the availability of the nurse to practice in a rapidly changing situation - a situation graphically outlined by the practitioners and managers in the project.

List of Abbreviations

BTec	Business and Technical Education Council
CCETSW	Central Council for the Education and Training of Social Workers
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CQSW	Certificate of Qualification in Social Work
CSC	Care Sector Consortium
CSS	Certificate in Social Studies
DES	Department of Education and Science
DipSW	Diploma in Social Work
DoE	Department of Employment
DoH	Department of Health
ENB	English National Board for Nursing, Midwifery and Health Visiting
LGTB	Local Government Training Body
NCVQ	National Council for Vocational Qualifications
NHSE	National Health Service Executive
NHSME	National Health Service Management Executive
NHSTA	National Health Service Training Authority
NVQ	National Vocational Qualification
QDSW	Qualifying Diploma in Social Work
SSD	Social Services Department
SSI	Social Services Inspectorate

APPENDIX A

Appendix A

NORTH YORKSHIRE COLLEGE OF HEALTH STUDIES

DIRECTORATE OF RESEARCH AND DEVELOPMENT

Mapping the Nursing Competencies required in Institutional and Community Settings in the context of Multidisciplinary Health Care Provision

List of those interviewed by job title

Phase 1

Senior Managers

Trust General Manager/Hospitals Unit
Trust Board Nurse/UGM/Community Services Manager
Trust Board Nurse/Nursing Development - Acute
Trust Board Nurse/Nursing Development - Community/Mental Health
Trust Board Nurse- Community/Mental Health
General Manager - Community (Adult)
General Manager - Community and Mental Health
Chief Nurse Adviser to FHSA
Divisional Manager - Medicine x 2
Divisional Manager - Surgery
Divisional Manager - named Hospital and Community Mental Health Resource Centres
Divisional Manager - Forensic Psychiatry
Divisional Manager - Community and Child Health
Director of Nursing - Trauma Directorate
Senior Nurse Manager - Adult Nursing
Senior Nurse Manager - Mental Health Services x 2
Senior Nurse Manager - Anaesthetic Services/Theatres
Senior Nurse Manager - Independent Sector, Adult Nursing
Senior Nurse Manager - Independent Sector, Mental Health Services

Middle Managers

Senior Nurse - Child Protection
Clinical Manager - Surgery x 2
Clinical Manager - Medicine
Nurse Manager - Theatres
Acute Admissions Officer
Clinical Nurse Manager
Community Nursing Service Manager
Senior Nurse - Forensic Psychiatry
Nursing Services Manager - named Mental Health Hospital
Clinical Team Leader - School Nursing
Community Nursing Services Manager
Senior Nurse - Mental Health Services
Community Hospital
Nursing Development Manager
Nurse Manager - Paediatric Services
Nurse Manager - Theatres

Grade G/H

Mental Illnes - Female Acute
Mental Health - Resource Centre
Mental Health - Acute x 2
Mental Health - Rehab x 2
Day Unit
Surgical
Theatres x 2
Elderly Care
Acute Admissions
Women's Health
Medicine - Acute
Health Visitor x 2
District Nursing Sister

Colleges

Principal/Chief Executive x3
Director x 6
Senior Teacher Mental Health x 2
Teacher Adult x 4
Teacher Mental Health x 4
Education Manager Adult/Mental Health x 5

Independent Sector

Director of Nursing Services
Senior Manager
Director of Nursing Services - Adult
Senior Manager - Mental Health

Phase 4

General Practitioners x 6
Health Visitors x 6
District Nurses x 6
Practice Nurses x 6

APPENDIX B

NORTH YORKSHIRE COLLEGE OF HEALTH STUDIES

DIRECTORATE OF RESEARCH AND DEVELOPMENT

Mapping the Nursing Competencies required in Institutional and Community Settings in the context of Multidisciplinary Health Care Provision.

Topic guide for Semi-Structured Interviews

1. What changes do you envisage within the service within the next five to ten years?

   a in hospital based nursing services

   b in community based nursing services

   c in the relationship between hospital and community services

2. What are currently the key aspects of the nurse's role?

3 In the context of multidisciplinary care, can you describe how the role will evolve over the next five to ten years?

4 What factors will influence this evolution?

5. a With what external agencies do nurses regularly interact in the discharge of their professional role?

   b To what extent is there clarity of role between agencies?

   c To what extent is there confusion of role between agencies?

6 What would be the effect of removing the nursing contribution from the multidisciplinary team?

7 What are the implications of the changes you describe for initial education and training?

8. a What are currently the key issues in the provision of placements for pre-registration students?

   b In view of your earlier comments concerning the evolution of the role of the nurse, what are the implications for the selection of placements for pre-registration students?

APPENDIX C

Appendix C

NORTH YORKSHIRE COLLEGE OF HEALTH STUDIES

DIRECTORATE OF RESEARCH AND DEVELOPMENT

Mapping the Nursing Competencies required in Institutional and Community Settings in the Context of Multi-disciplinary Health Care Provision (an exploratory study)

Focus Group Questions

1. What personal qualities are demanded of a nurse?
2. What knowledge and skills do you most offen draw on in assessing and planning for the health care needs of their client group?
3. What knowledge and skills do you most often draw on in order to implement and evaluate care?
4. Apart from the above, what are the key aspects of the role of the nurse?
5. What, if any, new knowledge and skills have you hade to develop during the last two years?
6. In your opinion, how is nursing viewed by others outside the profession?
7. Discuss in detail those aspects of your work which raise issues of professional accountability for you.
8. How satisfied are you with the concept and reality of multi-professional working?
9. How can newly qualified practitioners enhance their contribution to the multi-disciplinary care team?

APPENDIX D

MAPPING THE NURSING COMPETENCIES REQUIRED IN INSTITUTIONAL & COMMUNITY SETTINGS IN THE CONTEXT OF MULTI-DISCIPLINARY HEALTH CARE PROVISION - (AN EXPLORATORY STUDY)

BIOGRAPHICAL DATA - ADULT NURSING

In which setting do you normally work? (Please circle) — 3

Community	1
Hospital	2
Both Community & Hospital	3
Other - (please specify)	9

Please circle the code against the specific area(s) of practice in which you are primarily engaged. Please read all of the categories carefully before making your choice. If your area of practice is not listed please circle 'Other' (9) and specify

Accident & Emergency	1
Acute Admissions Unit	2
AIDS & HIV	3
Anaesthetics	4
Cardiothoracic Surgery	5
Community Hospital	6
Community Nursing	7
Continuing Care	8
Coronary Care	10
Day Hospital	11
Day Surgery	12
Dermatology	13
Diabetic	14
Ear, Nose & Throat	15
Elderly Care	16
Family Planning	17
General Medical	18
General Surgical	19
Genito-urinary Surgery	20
GP Practice Fundholders	21
GP Practice Non Fundholders	22
Gynaecology	23
Haematology	24
Intensive Care (excluding neonates)	25
Management/Administration	26
Neurology	27
Neurosurgery	28
Occupational Health	29
Oncology	30
Orthopaedics	31
Out Patients	32
Paediatrics	33
Palliative Care	34
Practice Nursing	35
Renal	36
Research	37
School Nursing	38
Special and Intensive Care Baby Unit	39
Stoma Care	40
Theatres	41
Other - (please specify)	9

In what capacity are you employed? (Please circle)

Practice Nurse	1
Staff Nurse	2
Ward Manager	3
Unit Manager	4
Health Visitor	5
District Nurse	6
Clinical Nurse Specialist	7
Other (Please specify job title)	9

4 How long have you been qualified as a registered nurse? (please indicate in box) ☐ yrs

5 How long have you worked in your current position? (please indicate in box) ☐ yrs

6 Sex (please circle) Male 1 Female 2

7 Grade (please circle)

D	1	G	4
E	2	H	5
F	3	I	6

Other (please specify) 9

8 Have you undertaken post-registration professional education in your area of practice? (eg ENB courses, Health Visitor, District Nurse Preparation etc) (please circle)

Yes	1
No	2
Don't know	3

If YES please list

1. .....
2. .....
3. .....
4. .....

9 Have you obtained any other academic qualifications? (Please circle)

Degree	1
Higher Degree	2

PC SAM 23.03.95/ABIODAT

MAPPING THE NURSING COMPETENCIES REQUIRED IN INSTITUTIONAL & COMMUNITY SETTINGS IN THE CONTEXT OF MULTI-DISCIPLINARY HEALTH CARE PROVISION (AN EXPLORATORY STUDY)

ADULT NURSING

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* Post-Reg - **R** or Don't Know - **DK** (3)		
1. CONTEXT OF CARE											
1. Having patient/client contact in **both** hospital and community settings	R	O	N	1	2	3	4	5	P	R	DK
2. Undertaking practice sensitive to the needs of patients/clients from multi-cultural backgrounds	R	O	N	1	2	3	4	5	P	R	DK
3. Working in conjunction with the voluntary and private sector	R	O	N	1	2	3	4	5	P	R	DK
4. Negotiating and retaining access to patient's/client's homes	R	O	N	1	2	3	4	5	P	R	DK
5. Undertaking nursing practice in settings physically remote from colleagues	R	O	N	1	2	3	4	5	P	R	DK
6. Dealing with issues related to public health	R	O	N	1	2	3	4	5	P	R	DK
7. Undertaking health screening programmes	R	O	N	1	2	3	4	5	P	R	DK
2. PATIENT/CLIENT CENTRED CARE											
8. Fostering autonomy of patients/clients in relation to health care decisions	R	O	N	1	2	3	4	5	P	R	DK
9. Maintaining and monitoring long term relationships with individuals, families or other social groups for health maintenance	R	O	N	1	2	3	4	5	P	R	DK
10. Making appropriate referrals when patients/clients seek legal advice	R	O	N	1	2	3	4	5	P	R	DK
11. Acting as patient/client advocate regarding quality of life issues	R	O	N	1	2	3	4	5	P	R	DK
12. Participating in decisions related to resuscitation based on quality of life indicators	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* **R**egularly (more than once a week) - **R**. **O**ccasionally - **O** or **N**ever - **N** (1)	*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)	*Please indicate whether this competence should be an outcome of pre or post registration education* **P**re-**R**eg - **P**. **P**ost-**R**eg - **R** or **D**on't **K**now - **DK** (3)
3 CLINICAL ASSESSMENT			
13. Undertaking comprehensive health care needs assessment of individuals	R O N	1 2 3 4 5	P R DK
14. Undertaking comprehensive health care needs assessment of families	R O N	1 2 3 4 5	P R DK
15. Undertaking comprehensive health care needs assessment of communities	R O N	1 2 3 4 5	P R DK
16. Assessing social life skills	R O N	1 2 3 4 5	P R DK
17. Assessing neurological function	R O N	1 2 3 4 5	P R DK
18. Taking the final decision to admit patients/clients to hospital within protocol criteria	R O N	1 2 3 4 5	P R DK
19. Making a daily assessment of all clients for whom I am responsible	R O N	1 2 3 4 5	P R DK
20. Recognising the effects of prescribed drugs and drug interactions	R O N	1 2 3 4 5	P R DK
21. Carrying out physical assessment of patients/clients	R O N	1 2 3 4 5	P R DK
4. NURSING ACTIONS			
22. Making and acting upon decisions which carry risks to patients/clients	R O N	1 2 3 4 5	P R DK
23. Making and acting upon decisions which carry risks to families	R O N	1 2 3 4 5	P R DK
24. Making and acting upon decisions which carry risks to communities	R O N	1 2 3 4 5	P R DK
25. Making and acting upon decisions which carry risks to the organisation	R O N	1 2 3 4 5	P R DK
26. Transporting drugs outside hospital premises	R O N	1 2 3 4 5	P R DK
27. Administering and disposing of medicines (including controlled drugs) outside the hospital situation	R O N	1 2 3 4 5	P R DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* **R**egularly (more than once a week) - **R**, **O**ccasionally - **O** or **N**ever - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* **Pre-Reg - P**, **Post-Reg - R** or **Don't Know - DK** (3)		
4. NURSING ACTIONS cont.											
28. Interpreting and applying Health and Safety legislation	R	O	N	1	2	3	4	5	P	R	DK
29. Interpreting and applying The Community Care Act	R	O	N	1	2	3	4	5	P	R	DK
30. Interpreting and applying The Children Act	R	O	N	1	2	3	4	5	P	R	DK
31. Interpreting and applying The Mental Health Act	R	O	N	1	2	3	4	5	P	R	DK
32. Attending court hearings tribunals and engagement with the Criminal Justice System	R	O	N	1	2	3	4	5	P	R	DK
33. Attending meetings called for the purpose of child protection	R	O	N	1	2	3	4	5	P	R	DK
34. Allocating patients clients to diagnostic groups on the basis of which treatment is initiated	R	O	N	1	2	3	4	5	P	R	DK
35. Facilitating group therapy meetings	R	O	N	1	2	3	4	5	P	R	DK
5. SPECIFIC NURSING SKILLS											
36. Adjusting patient medication in response to laboratory findings	R	O	N	1	2	3	4	5	P	R	DK
37. Interpreting blood results and adjusting treatment accordingly	R	O	N	1	2	3	4	5	P	R	DK
38. Confirming expected death	R	O	N	1	2	3	4	5	P	R	DK
39. Prescribing drugs within protocols	R	O	N	1	2	3	4	5	P	R	DK
40. Carrying out intubation and/or extubation	R	O	N	1	2	3	4	5	P	R	DK
41. Managing and monitoring Central Venous Pressure lines	R	O	N	1	2	3	4	5	P	R	DK
42. Taking blood from arterial lines	R	O	N	1	2	3	4	5	P	R	DK
43. Carrying out venepuncture	**R**	**O**	**N**	**1**	**2**	**3**	**4**	**5**	**P**	**R**	**DK**

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)			*Please rate the importance of this competence for your role in the future* 1 - of no importance 3 - neither important/unimportant 5 - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* Pre-Reg - **P**, Post-Reg - **R** or Don't Know - **DK** (3)		
5. SPECIFIC NURSING SKILLS cont.											
44. Carrying out defibrillation	R	O	N	1	2	3	4	5	P	R	DK
45. Inserting a peripheral intra venous cannula	R	O	N	1	2	3	4	5	P	R	DK
46. Initiating an IV regime within protocols	R	O	N	1	2	3	4	5	P	R	DK
47. Administration of IV drugs	R	O	N	1	2	3	4	5	P	R	DK
48. Running cervical cytology clinics	R	O	N	1	2	3	4	5	P	R	DK
49. Carrying out male catheterisation	R	O	N	1	2	3	4	5	P	R	DK
50. Assisting with the induction of anaesthesia	R	O	N	1	2	3	4	5	P	R	DK
51. Assisting the surgeon	R	O	N	1	2	3	4	5	P	R	DK
52. Assisting with tracheostomy formation in critical care environments	R	O	N	1	2	3	4	5	P	R	DK
53. Removing foreign bodies from the eye	R	O	N	1	2	3	4	5	P	R	DK
54. Interpreting X-rays	R	O	N	1	2	3	4	5	P	R	DK
55. Undertaking breast examination	R	O	N	1	2	3	4	5	P	R	DK
56. Undertaking pelvic or prostate examination	R	O	N	1	2	3	4	5	P	R	DK
6. CLINICAL EVALUATION											
57. Using computer held data to inform the evaluation of client care outcomes	R	O	N	1	2	3	4	5	P	R	DK
58. Undertaking evaluation strategies with the use of audit tools	R	O	N	1	2	3	4	5	P	R	DK
59. Accessing local databases held on computer	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* Pre-Reg - **P**, Post-Reg - **R** or Don't Know - **DK** (3)		
6. CLINICAL EVALUATION cont											
60. Accessing national databases held on computer	R	O	N	1	2	3	4	5	P	R	DK
61. Planning systems of nursing activity which satisfy agreed standards at local, unit or district level	R	O	N	1	2	3	4	5	P	R	DK
62. Evaluating quality improvements to assure the on-going quality of nursing services	R	O	N	1	2	3	4	5	P	R	DK
63. Participating in multi-disciplinary clinical audit	R	O	N	1	2	3	4	5	P	R	DK
7. MULTI-DISCIPLINARY WORKING											
64. Actively participating in multi-disciplinary team meetings	R	O	N	1	2	3	4	5	P	R	DK
65. Actively working with social workers	R	O	N	1	2	3	4	5	P	R	DK
66. Actively working with occupational therapists	R	O	N	1	2	3	4	5	P	R	DK
67. Actively working with chiropodist/podiatrists	R	O	N	1	2	3	4	5	P	R	DK
68. Actively working with dieticians	R	O	N	1	2	3	4	5	P	R	DK
69. Actively working with consultants	R	O	N	1	2	3	4	5	P	R	DK
70. Actively working with psychologists	R	O	N	1	2	3	4	5	P	R	DK
71. Actively working with GPs	R	O	N	1	2	3	4	5	P	R	DK
72. Actively working with pharmacists	R	O	N	1	2	3	4	5	P	R	DK
73. Participating in meetings in which decisions are made regarding selection of key workers	R	O	N	1	2	3	4	5	P	R	DK
74. Co-ordinating the multi-disciplinary team in discharge planning	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* **R**egularly (more than once a week) - **R**, **O**ccasionally - **O** or **N**ever - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* **Pre-Reg** - **P**, **Post-Reg** - **R** or **D**on't **K**now - **DK** (3)		
7. MULTI-DISCIPLINARY WORKING cont.											
75. Participating in multi-disciplinary standard setting	R	O	N	1	2	3	4	5	P	R	DK
76. Participating in the writing of shared protocols for care	R	O	N	1	2	3	4	5	P	R	DK
77. Collaborating with the multi-disciplinary team in reaching clinical decisions in ethically challenging situations	R	O	N	1	2	3	4	5	P	R	DK
78. Contributing to shared multi-disciplinary team patient notes/records	R	O	N	1	2	3	4	5	P	R	DK
79. Actively working with physiotherapists	R	O	N	1	2	3	4	5	P	R	DK
80. Actively working with speech therapists0	R	O	N	1	2	3	4	5	P	R	DK
81. Actively working with audiologists	R	O	N	1	2	3	4	5	P	R	DK
82. Actively working with operating department assistants (ODA)	R	O	N	1	2	3	4	5	P	R	DK
8. RESEARCH											
83. Identifying researchable problems	R	O	N	1	2	3	4	5	P	R	DK
84. Writing or collaborating in writing a research proposal	R	O	N	1	2	3	4	5	P	R	DK
85. Communicating research findings to staff through formal and informal processes	R	O	N	1	2	3	4	5	P	R	DK
86. Effecting change based on research findings	R	O	N	1	2	3	4	5	P	R	DK
87. Critically analysing the findings of research studies	R	O	N	1	2	3	4	5	P	R	DK
9. PERSONAL & PROFESSIONAL DEVELOPMENT											
88. Completing reflective diaries	R	O	N	1	2	3	4	5	P	R	DK
89. Maintaining a personal and professional portfolio	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* **R**egularly (more than once a week) - **R**, **O**ccasionally - **O** or **N**ever - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* **Pre-Reg - P**, **Post-Reg - R** or **Don't Know - DK** (3)		
10. EDUCATION											
90. Undertaking **informal** health education activities with individuals	R	O	N	1	2	3	4	5	P	R	DK
91. Undertaking **informal** health education activities with families and carers	R	O	N	1	2	3	4	5	P	R	DK
92. Operating as a mentor for students and staff	R	O	N	1	2	3	4	5	P	R	DK
93. Assessing National Vocational Qualifications (NVQ) competencies	R	O	N	1	2	3	4	5	P	R	DK
94. Assessing student nurses	R	O	N	1	2	3	4	5	P	R	DK
95. Participating in a process of clinical supervision	R	O	N	1	2	3	4	5	P	R	DK
96. Disseminating information about educational resources and opportunities to staff	R	O	N	1	2	3	4	5	P	R	DK
97. Delivering **formal** health education activities/programmes to individuals	R	O	N	1	2	3	4	5	P	R	DK
98. Delivering **formal** health education activities/programmes to families	R	O	N	1	2	3	4	5	P	R	DK
99. Supporting junior medical colleagues	R	O	N	1	2	3	4	5	P	R	DK
100. Educating patients/clients/carers in the use of equipment in community settings	R	O	N	1	2	3	4	5	P	R	DK
11. MANAGING CHANGE											
101. Contributing to meetings regarding the business strategy of the Trust	R	O	N	1	2	3	4	5	P	R	DK
102. Contributing to meetings at which broad professional issues are discussed	R	O	N	1	2	3	4	5*	P	R	DK
103. Formally presenting a case for change	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)	*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)	*Please indicate whether this competence should be an outcome of pre or post registration education* **Pre-Reg - P**, **Post-Reg - R** or **Don't Know - DK** (3)

12. MANAGEMENT											
104. Reviewing workload priorities as a response to changing contexts	R	O	N	1	2	3	4	5	P	R	DK
105. Monitoring the actions of others to whom responsibility for patient/client care has been delegated	R	O	N	1	2	3	4	5	P	R	DK
106. Managing the allocation of patients/clients to a multi-skilled team	R	O	N	1	2	3	4	5	P	R	DK
107. Managing care within the context of change	R	O	N	1	2	3	4	5	P	R	DK
108. Dealing with formal requests for information from **organisations** outside the National Health Service	R	O	N	1	2	3	4	5	P	R	DK
109. Chairing meetings	R	O	N	1	2	3	4	5	P	R	DK
110. Inputting data to computerised information management systems	R	O	N	1	2	3	4	5	P	R	DK
111. Managing a budget	R	O	N	1	2	3	4	5	P	R	DK
112. Managing personnel issues and policies	R	O	N	1	2	3	4	5	P	R	DK
113. Negotiating a care package for individual patients/clients	R	O	N	1	2	3	4	5	P	R	DK
114. Taking the final decision to discharge patients/clients within defined protocols	R	O	N	1	2	3	4	5	P	R	DK
115. Writing discharge letters to GPs	R	O	N	1	2	3	4	5	P	R	DK
116. Managing nurse led clinics	R	O	N	1	2	3	4	5	P	R	DK
117. Initiating and maintaining the use of patient/client held records	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* **R**egularly (more than once a week) - **R**. **O**ccasionally - **O** or **N**ever - **N** (1)	*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)	*Please indicate whether this competence should be an outcome of pre or post registration education* **Pre-Reg - P**, **Post-Reg - R** or **D**on't **K**now - **DK** (3)
13. COMMUNICATION			
118. Using counselling skills in dealings with clients	R O N	1 2 3 4 5	P R DK
119. Using counselling skills in dealings with their families	R O N	1 2 3 4 5	P R DK
120. Using counselling skills in dealings with colleagues	R O N	1 2 3 4 5	P R DK
121. Dealing personally with patients, their families or carers who make a complaint	R O N	1 2 3 4 5	P R DK

Thank you for completing our questionnaire.

Please return as soon as possible to:-

FREEPOST
Department of Research
North Yorkshire College of Health Studies
Harrogate General Hospital
Knaresborough Road
HARROGATE
North Yorkshire
HG2 7BR

APPENDIX E

MAPPING THE NURSING COMPETENCIES REQUIRED IN INSTITUTIONAL & COMMUNITY SETTINGS IN THE CONTEXT OF MULTI-DISCIPLINARY HEALTH CARE PROVISION - (AN EXPLORATORY STUDY)

BIOGRAPHICAL DATA - MENTAL HEALTH NURSING

In which setting do you normally work? (Please circle)

Community	1
Hospital	2
Both Community & Hospital	3
Other - (please specify)	9

Please circle the code against the specific area(s) of practice in which you are primarily engaged. Please read all of the categories carefully before making your choice. If your area of practice is not listed please circle 'Other' (9) and specify

Acute Mental Health Problems	1
Adolescent Care	2
Child Care	3
Child & Adolescent Care	4
Community Unit for Elderly	5
Community Unit 'Other'	6
Crisis Intervention Team	7
Day Care	8
Eating Disorders	10
Elderly Care	11
Forensic Psychiatry	12
Neuro Psychiatry	13
Serious/Enduring Mental Health Problems	14
Substance Misuse	15
Other - (please specify)	9

In what capacity are you employed? (Please circle)

Staff Nurse	1
Ward Manager	2
Unit Manager	3
Clinical Nurse Specialist	4
Community Psychiatric Nurse	5
Other (Please specify job title)	9

4 How long have you been qualified as a registered nurse? (please indicate in box) ☐ yrs

5 How long have you worked in your current position? (please indicate in box) ☐ yrs

6 Sex (please circle) Male 1 Female 2

7 Grade (please circle)

D	1	G	4
E	2	H	5
F	3	I	6

Other (please specify) 9

8 Have you undertaken post-registration professional education in your area of practice? (eg ENB courses, Community Psychiatric Nursing Preparation etc) (please circle)

Yes	1
No	2
Don't know	3

If **YES** please list

1. .....
2. .....
3. .....
4. .....

9 Have you obtained any other academic qualifications? (Please circle)

Degree	1
Higher Degree	2

MAPPING THE NURSING COMPETENCIES REQUIRED IN INSTITUTIONAL & COMMUNITY SETTINGS IN THE CONTEXT OF MULTI-DISCIPLINARY HEALTH CARE PROVISION (AN EXPLORATORY STUDY)

MENTAL HEALTH NURSING

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* Pre-Reg - **P**, Post-Reg - **R** or Don't Know - **DK** (3)		
1. CONTEXT OF CARE											
1. Having patient/client contact in **both** hospital and community settings	R	O	N	1	2	3	4	5	P	R	DK
2. Undertaking practice sensitive to the needs of patients/clients from multi-cultural backgrounds	R	O	N	1	2	3	4	5	P	R	DK
3. Working in conjunction with the voluntary and private sector	R	O	N	1	2	3	4	5	P	R	DK
4. Negotiating and retaining access to patient's/client's homes	R	O	N	1	2	3	4	5	P	R	DK
5. Undertaking nursing practice in settings physically remote from colleagues	R	O	N	1	2	3	4	5	P	R	DK
6. Challenging institutional practices	R	O	N	1	2	3	4	5	P	R	DK
7. Contributing to the care of patients/clients who are homeless	R	O	N	1	2	3	4	5	P	R	DK
8. Contributing to the care of patients/clients undertaking custodial sentences	R	O	N	1	2	3	4	5	P	R	DK
9. Contributing to the care of patients/clients who are subject to probation orders	R	O	N	1	2	3	4	5	P	R	DK
10. Working with a patient/client who exhibits challenging behaviour	R	O	N	1	2	3	4	5	P	R	DK
2. PATIENT/CLIENT CENTRED CARE											
11. Fostering autonomy of patients/clients in relation to health care decisions	R	O	N	1	2	3	4	5	P	R	DK
12. Maintaining and monitoring long term relationships with individuals, families or other social groups for health maintenance	R	O	N	1	2	3	4	5	P	R	DK
13. Making appropriate referrals when patients/clients seek legal advice	R	O	N	1	2	3	4	5	P	R	DK
14. Acting as patient/client advocate regarding quality of life issues	R	O	N	1	2	3	4	5	P	R	DK
15. Drawing up contracts of care with individual patients/clients	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* **Pre-Reg - P**, **Post-Reg - R** or **Don't Know - DK** (3)		
3. CLINICAL ASSESSMENT											
16. Undertaking comprehensive health care needs assessment of individuals	R	O	N	1	2	3	4	5	P	R	DK
17. Undertaking comprehensive health care needs assessment of families	R	O	N	1	2	3	4	5	P	R	DK
18. Undertaking comprehensive health care needs assessment of communities	R	O	N	1	2	3	4	5	P	R	DK
19. Assessing social/life skills	R	O	N	1	2	3	4	5	P	R	DK
20. Assessing neurological function	R	O	N	1	2	3	4	5	P	R	DK
21. Taking the final decision to admit patients/clients to hospital within protocol criteria	R	O	N	1	2	3	4	5	P	R	DK
22. Making a daily assessment of all clients for whom I am responsible	R	O	N	1	2	3	4	5	P	R	DK
23. Recognising the effects of prescribed drugs and drug interactions	R	O	N	1	2	3	4	5	P	R	DK
24. Carrying out physical assessment of patients/clients	R	O	N	1	2	3	4	5	P	R	DK
4. NURSING ACTIONS											
25. Making and acting upon decisions which carry risks to patients/clients	R	O	N	1	2	3	4	5	P	R	DK
26. Making and acting upon decisions which carry risks to families	R	O	N	1	2	3	4	5	P	R	DK
27. Making and acting upon decisions which carry risks to communities	R	O	N	1	2	3	4	5	P	R	DK
28. Making and acting upon decisions which carry risks to the organisation	R	O	N	1	2	3	4	5	P	R	DK
29. Making and acting upon decisions which carry risk to self	R	O	N	1	2	3	4	5	P	R	DK
30. Transporting drugs outside hospital premises	R	O	N	1	2	3	4	5	P	R	DK
31. Administering and disposing of medicines (including controlled drugs) outside the hospital situation	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* **R**egularly (more than once a week) - **R**, **O**ccasionally - **O** or **N**ever - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* **Pre-Reg - P**, **Post-Reg - R** or **D**on't **K**now - **DK** (3)		
4. NURSING ACTIONS cont.											
32. Interpreting and applying Health and Safety legislation	R	O	N	1	2	3	4	5	P	R	DK
33. Interpreting and applying The Community Care Act	R	O	N	1	2	3	4	5	P	R	DK
34. Interpreting and applying The Children Act	R	O	N	1	2	3	4	5	P	R	DK
35. Interpreting and applying The Mental Health Act	R	O	N	1	2	3	4	5	P	R	DK
36. Attending court hearings/tribunals and engagement with the Criminal Justice System	R	O	N	1	2	3	4	5	P	R	DK
37. Attending meetings called for the purpose of child protection	R	O	N	1	2	3	4	5	P	R	DK
38. Allocating patients/clients to diagnostic groups on the basis of which treatment is initiated	R	O	N	1	2	3	4	5	P	R	DK
39. Facilitating group therapy meetings	R	O	N	1	2	3	4	5	P	R	DK
5. SPECIFIC NURSING SKILLS											
40. Adjusting patient medication in response to laboratory findings	R	O	N	1	2	3	4	5	P	R	DK
41. Interpreting blood results and adjusting treatment accordingly	R	O	N	1	2	3	4	5	P	R	DK
42. Confirming expected death	R	O	N	1	2	3	4	5	P	R	DK
43. Prescribing drugs within protocols	R	O	N	1	2	3	4	5	P	R	DK
44. Being accountable for and **personally** administering electro-convulsive therapy	R	O	N	1	2	3	4	5	P	R	DK
45. Assessing, anticipating and diffusing aggression	R	O	N	1	2	3	4	5	P	R	DK

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6. CLINICAL EVALUATION											
46. Using computer held data to inform the evaluation of client care outcomes	R	O	N	1	2	3	4	5	P	R	DK
47. Undertaking evaluation strategies with the use of audit tools	R	O	N	1	2	3	4	5	P	R	DK
48. Accessing local databases held on computer	R	O	N	1	2	3	4	5	P	R	DK
49. Accessing national databases held on computer	R	O	N	1	2	3	4	5	P	R	DK
50. Planning systems of nursing activity which satisfy agreed standards at local, unit or district level	R	O	N	1	2	3	4	5	P	R	DK
51. Evaluating quality improvements to assure the on-going quality of nursing services	R	O	N	1	2	3	4	5	P	R	DK
52. Participating in multi-disciplinary clinical audit	R	O	N	1	2	3	4	5	P	R	DK
7. MULTI-DISCIPLINARY WORKING											
53. Actively participating in multi-disciplinary team meetings	R	O	N	1	2	3	4	5	P	R	DK
54. Actively working with social workers	R	O	N	1	2	3	4	5	P	R	DK
55. Actively working with occupational therapists	R	O	N	1	2	3	4	5	P	R	DK
56. Actively working with chiropodist podiatrists	R	O	N	1	2	3	4	5	P	R	DK
57. Actively working with dieticians	R	O	N	1	2	3	4	5	P	R	DK
58. Actively working with consultants	R	O	N	1	2	3	4	5	P	R	DK
59. Actively working with psychologists	R	O	N	1	2	3	4	5	P	R	DK
60. Actively working with GPs	R	O	N	1	2	3	4	5	P	R	DK
61. Actively working with pharmacists	R	O	N	1	2	3	4	5	P	R	DK

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7. MULTI-DISCIPLINARY WORKING cont.											
62. Participating in meetings in which decisions are made regarding selection of key workers	R	O	N	1	2	3	4	5	P	R	DK
63. Co-ordinating the multi-disciplinary team in discharge planning	R	O	N	1	2	3	4	5	P	R	DK
64. Participating in multi-disciplinary standard setting	R	O	N	1	2	3	4	5	P	R	DK
65. Participating in the writing of shared protocols for care	R	O	N	1	2	3	4	5	P	R	DK
66. Collaborating with the multi-disciplinary team in reaching clinical decisions in ethically challenging situations	R	O	N	1	2	3	4	5	P	R	DK
67. Contributing to shared multi-disciplinary team patient notes/records	R	O	N	1	2	3	4	5	P	R	DK
68. Actively working with probation officers	R	O	N	1	2	3	4	5	P	R	DK
69. Collaborating with the multi-disciplinary team in delivery of the care programme approach	R	O	N	1	2	3	4	5	P	R	DK
8. RESEARCH											
70. Identifying researchable problems	R	O	N	1	2	3	4	5	P	R	DK
71. Writing or collaborating in writing a research proposal	R	O	N	1	2	3	4	5	P	R	DK
72. Communicating research findings to staff through formal and informal processes	R	O	N	1	2	3	4	5	P	R	DK
73. Effecting change based on research findings	R	O	N	1	2	3	4	5	P	R	DK
74. Critically analysing the findings of research studies	R	O	N	1	2	3	4	5	P	R	DK
9. PERSONAL & PROFESSIONAL DEVELOPMENT											
75. Completing reflective diaries	R	O	N	1	2	3	4	5	P	R	DK
76. Maintaining a personal and professional portfolio	R	O	N	1	2	3	4	5	P	R	DK

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10. EDUCATION											
77. Undertaking **informal** health education activities with individuals	R	O	N	1	2	3	4	5	P	R	DK
78. Undertaking **informal** health education activities with families and carers	R	O	N	1	2	3	4	5	P	R	DK
79. Operating as a mentor for students and staff	R	O	N	1	2	3	4	5	P	R	DK
80. Assessing National Vocational Qualifications (NVQ) competencies	R	O	N	1	2	3	4	5	P	R	DK
81. Assessing student nurses	R	O	N	1	2	3	4	5	P	R	DK
82. Participating in a process of clinical supervision	R	O	N	1	2	3	4	5	P	R	DK
83. Disseminating information about educational resources and opportunities	R	O	N	1	2	3	4	5	P	R	DK
11. MANAGING CHANGE											
84. Contributing to meetings regarding the business strategy of the Trust	R	O	N	1	2	3	4	5	P	R	DK
85. Contributing to meetings at which broad professional issues are discussed	R	O	N	1	2	3	4	5	P	R	DK
86. Formally presenting a case for change	R	O	N	1	2	3	4	5	P	R	DK
12. MANAGEMENT											
87. Reviewing workload priorities as a response to changing contexts	R	O	N	1	2	3	4	5	P	R	DK
88. Monitoring the actions of others to whom responsibility for patient/client care has been delegated	R	O	N	1	2	3	4	5	P	R	DK
89. Managing the allocation of patients/clients to a multi-skilled team	R	O	N	1	2	3	4	5	P	R	DK
90. Managing care within the context of change	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* Pre-Reg - **P**, Post-Reg - **R** or Don't Know - **DK** (3)		
12. MANAGEMENT cont.											
91. Dealing with formal requests for information from **organisations** outside the National Health Service	R	O	N	1	2	3	4	5	P	R	DK
92. Chairing meetings	R	O	N	1	2	3	4	5	P	R	DK
93. Inputting data to computerised information management systems	R	O	N	1	2	3	4	5	P	R	DK
94. Managing a budget	R	O	N	1	2	3	4	5	P	R	DK
95. Managing personnel issues and policies	R	O	N	1	2	3	4	5	P	R	DK
96. Negotiating a care package for individual patients/clients	R	O	N	1	2	3	4	5	P	R	DK
97. Taking the final decision to discharge patients/clients within defined protocols	R	O	N	1	2	3	4	5	P	R	DK
98. Writing discharge letters to GPs	R	O	N	1	2	3	4	5	P	R	DK
99. Managing nurse led clinics	R	O	N	1	2	3	4	5	P	R	DK
13. COMMUNICATION											
100. Establishing an informal, relaxed working relationship with a patients/clients	R	O	N	1	2	3	4	5	P	R	DK
101. Establishing a therapeutic relationship with a patient/client who presents with a history of sexual abuse	R	O	N	1	2	3	4	5	P	R	DK
102. Working within a framework of an established model of counselling	R	O	N	1	2	3	4	5	P	R	DK
103. Using a formal model of counselling	R	O	N	1	2	3	4	5	P	R	DK
104. Giving formal counselling supervision	R	O	N	1	2	3	4	5	P	R	DK
105. Handling catharsis	R	O	N	1	2	3	4	5	P	R	DK

COMPETENCE STATEMENT	*Students allocated to you at present will be able to observe you doing this* Regularly (more than once a week) - **R**, Occasionally - **O** or Never - **N** (1)			*Please rate the importance of this competence for your role in the future* **1** - of no importance **3** - neither important/unimportant **5** - of vital importance (2)					*Please indicate whether this competence should be an outcome of pre or post registration education* Pre-Reg - **P**, Post-Reg - **R** or Don't Know - **DK** (3)		
13. COMMUNICATION cont.											
106. Establishing a trusting relationship with a client who finds trust difficult	R	O	N	1	2	3	4	5	P	R	DK
107. Dealing personally with patients, their families or carers who make a complaint	R	O	N	1	2	3	4	5	P	R	DK

Thank you for completing our questionnaire.

Please return as soon as possible to:-

FREEPOST
Department of Research
North Yorkshire College of Health Studies
Harrogate General Hospital
Knaresborough Road
HARROGATE
North Yorkshire
HG2 7BR

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APPENDIX F

Appendix F

NORTH YORKSHIRE COLLEGE OF HEALTH STUDIES

DIRECTORATE OF RESEARCH & DEVELOPMENT

Mapping the Nursing Competencies required in Institutional and Community Settings in the context of Multidisciplinary Health Care Provision

Multidisciplinary focus group questions

1 To what degree is there clarity of role and function between members of / within the MDT

2 To what extent is there confusion of roles and function within the MDT

3 How would you describe the specific contribution of the nurse to the MDT

4 What changes do you envisage in the service over the next five to ten years

5 What are the implications of this change for the multidisciplinary team.

APPENDIX G

NORTH YORKSHIRE COLLEGE OF HEALTH STUDIES

DIRECTORATE OF RESEARCH AND DEVELOPMENT

Mapping the Nursing Competencies required in Institutional and Community Settings in the context of Multidisciplinary Health Care Provision.

Topic guide for Semi-Structured GP Interviews

1 Can you briefly describe the practice and its population?

2 Could you give an overview of the services provided by the practice?

3 Could y describe the nursing services which you currently provide or for which you contract?

4 Do your practice nurses visit patients in their homes?

5 Can you list the professionals who constitute the primary health care team?

6 How do they co-ordinate their work?

7 Can you describe the impact of the Comunity Care Act and of the reduction in hospital beds on the primary health care team?

8 What changes do you envisage in the pattern of primary health care delivery over the next five to ten years:

a first of all in relation to acute services?
b secondly in relation to mental health care?

9 What impact will these have on the role of the various members of the MDT?

10 What are the educational implications for nurses?

Practice Nurses

1 Could you give an overview of the services provided by the practice?

2 Can you describe your contact with other nurses attached to the practice?

3 Can you list the professionals who constitute the primary health care team?

4 How do these professionals co-ordinate their work?

5 Can you describe the impact of the Community Care Act and of the reduction in hospital beds on the primary health care team?

6 What chages do you envisage in the pattern of primary health care delivery over the next five to ten years?

a in relation to acute servuces
b in relation to mental health care

7 What impact will these have on the role of the various members of the MDT?

8 What impact will these have on your role in particular?

9 What are the educational implications for you?

Health Visitors and Community Nurses

1 With how many GP practices do you work?

2 Can you describe your contact with other nurses attached to or employed by the practice?

3 Can you list the professionals who constitute the primary health care team?

4 How do they coordinate their work?

5 Can you describe the impact of the Community Care Act and of the reduction in hospital beds on the primary health care team?

6 What chages do you envisage in the pattern of primary health care delivery over the next five to ten years?

a in relation to acute services
b in relation to mental health care

7 What impact will these have on the role of the various members of the MDT?

8 What impact will these have on your role in particular?

9 What are the educational implications for you?

APPENDIX H

Appendix H Mental Health Competencies by Setting

	COMMUNITY SETTINGS		HOSPITAL/RESIDENTIAL SETTINGS
1.1	Having patient/client contact in both hospital and community settings	1.2	Undertaking practice sensitive to the needs of patients from multi-cultural backgrounds
1.3	Working in conjunction with the voluntary and private sectors	1.7	Contributing to the care of clients who are homeless
1.4	Negotiating and retaining access to patient's homes	1.8	Contributing to the care of clients who are undertaking custodial sentences
2.2	Maintaining and monitoring long-term relationships with individuals, families or other social groups for health maintenance	1.9	Contributing to the care of clients subject to probation orders
3.2	Undertaking comprehensive health care needs assessment of families	1.10	Working with a client who exhibits challenging behaviour
4.2	Making and acting upon decisions which carry risks to families	2.3	Making appropriate referrals when clients seek legal advice
4.5	Transporting drugs outside hospital premises	3.7	Making a daily assessment of all clients for whom I am responsible
4.6	Administration and disposing of medicines outside the hospital situation	4.10	Interpreting and applying the Mental Health Act
6.7	Participating in multi-disciplinary audit	4.11	Attending court hearings and engagement with the criminal justice system
7.1	Actively participating in multi-disciplinary team meetings	5.4	Prescribing drugs within protocols
7.8	Actively working with GPs	5.6	Assessing anticipating and diffusing aggression
7.10	Participating in meetings in which decisions are made regarding the selection of key workers	7.2	Actively working with probation officers
7.12	Participating in multi-disciplinary standard setting	10.7	Assessing NVQ competencies
11.2	Contributing to meetings at which broad professional issues are discussed	12.2	Monitoring the actions of others to whom responsibility for patient care has been delegated
11.3	Formally presenting a case for change	12.3	Managing the allocation of patients to a multi-skilled team
12.6	Chairing meetings	13.2	Establishing a therapeutic relationship with a patient/client who presents with a history of sexual abuse
12.7	Inputting data to computerised information management systems		
12.11	Taking the final decision to discharge patients within defined protocols		
12.12	Writing discharge letters to GPs		
12.13	Managing nurse-led clinics		
13.3	Working within a framework of an established model of counselling		

APPENDIX I

Appendix I Adult Competencies by Setting

	COMMUNITY SETTINGS		HOSPITAL SETTINGS		COMBINED SETTINGS
1.1	Having patient contact in both hospital and community settings	2.5	Participating in decisions related to resuscitation based on quality of life indicators	1.1	Having patient contact in both hospital and community settings
1.2	Undertaking practice sensitive to the needs of patients from multi-cultural backgrounds	3.5	Assessing neurological function	1.6	Dealing with issues related to public health
1.3	Working in conjunction with the voluntary and private sectors	3.7	Making a daily assessment of all clients for whom I am responsible	3.2	Undertaking comprehensive health care needs assessment of families
1.4	Negotiating and retaining access to patient's homes	3.8	Recognising the effects of prescribed drugs and drug interactions	3.7	Making a daily assessment of all clients for whom I am responsible
1.5	Undertaking nursing practice in settings physically remote from colleagues	3.9	Carrying out physical assessment of clients	3.8	Recognising the effects of prescribed drugs and drug interactions
1.6	Dealing with issues related to public health	5.1	Adjusting patient medication in response to laboratory findings	3.9	Carrying out physical assessment of clients
1.7	Undertaking health screening programmes	5.5	Carrying out intubation/extubation	4.2	Making and acting upon decisions which carry risks to families
2.1	Fostering autonomy of patients in relation to health care decisions	5.6	Managing and monitoring CVP lines	4.3	Making and acting upon decisions which carry risks to communities
2.2	Maintaining and monitoring long term relationships with individuals, families or other social groups for health maintenance	5.7	Taking blood from arterial lines	4.5	Transporting drugs outside hospital premises
3.2	Undertaking comprehensive health care needs assessment of families	5.9	Carrying out defibrillation	4.6	Administration and disposing of medicines outside the hospital situation
3.3	Undertaking comprehensive health care needs assessment of communities	5.10	Inserting a peripheral IV cannula	4.8	Interpreting and applying the Community Care Act
4.2	Making and acting upon decisions which carry risks to families	5.12	Administration of IV drugs	4.11	Attending court hearings/tribunals and engagement with the criminal justice system
4.3	Making and acting upon decisions which carry risks to communities	5.15	Assisting with the induction of anaesthesia	4.12	Attending child protection meetings
4.5	Transporting drugs outside hospital premises	5.16	Assisting the surgeon	4.13	Allocating patients to diagnostic groups on the basis of treatment initiated
4.6	Administration and disposing of medicines outside the hospital situation	5.17	Assisting with tracheostomy formation	4.14	Facilitating group therapy meetings
4.8	Interpreting and applying the Community Care Act	5.19	Interpreting x-rays	5.1	Adjusting patient medication as a response to lab findings
4.9	Interpreting and applying the Children Act	6.5	Planning systems of nursing activity which satisfy agreed standards at local, unit or district level	5.5	Carrying out intubation or extubation
4.11	Attending court hearings/tribunals and engagement with the criminal justice system	7.6	Actively working with consultants	5.6	Managing/monitoring CVP lines
4.12	Attending child protection meetings	7.9	Actively working with pharmacists	5.13	Running cervical cytology clinics
4.13	Allocating patients to diagnostic groups on the basis of treatment initiated	7.11	Co-ordinating the multi-disciplinary team in discharge planning	5.14	Carrying out male catheterisation
4.14	Facilitating group therapy meetings	7.14	Collaborating with the multi-disciplinary team in reaching decisions in ethically challenging situations	5.20	Undertaking breast examination

	COMMUNITY SETTINGS		HOSPITAL SETTINGS		COMBINED SETTINGS
5.13	Running cervical cytology clinics	7.16	Actively working with physiotherapist	6.4	Accessing national computer databases
5.14	Carrying out male catheterisation	7.19	Actively working with OOAs	7.1	Actively participating in multi-disciplinary team meetings
5.20	Undertaking breast examination	8.1	Identifying researchable problems	7.4	Actively working with chiropodists/podiatrists
6.1	Using computer held data to inform client care outcomes evaluation	10.3	Operating as a mentor for students and staff	7.8	Actively working with GPs
6.2	Undertaking evaluation strategies with the aid of audit tools	10.4	Assessing NVQ competencies	7.16	Actively working with physiotherapists
6.3	Accessing local databases held on computer	10.6	Participating in clinical supervision	7.18	Actively working with audiologists
6.4	Accessing national databases on computer	10.7	Disseminating information about ed. Resources and opportunities	7.19	Actively working with OOAs
6.5	Planning systems of nursing activity which satisfy local, unit or district standards	10.10	Supporting junior medical colleagues	9.1	Completing reflective diaries
7.1	Actively participating in multi-disciplinary team meetings	12.2	Monitoring the actions of others to whom patient care has been delegated	10.1	Undertaking informal health education activities with individuals
7.4	Actively working with chiropodists/podiatrists	12.3	Managing the allocation of patients to a multi-skilled team	10.2	Undertaking informal health education activities with families/carers
7.8	Actively working with GPs	12.8	Managing a budget	10.3	Operating as a mentor for students and staff
7.10	Participating in meetings in which decisions are made regarding the selection of key workers	12.12	Writing discharge letters to GPs	10.4	Assessing NVQs
7.18	Actively working with audiologists	13.4	Dealing personally with patients/families/carers who make a complaint	10.6	Participating in clinical supervision
8.1	Identifying researchable problems			10.8	Delivering formal health education programmes or activities to individuals
9.1	Completing reflective diaries			10.9	Delivering formal health education programmes or activities to families
10.1	Undertaking informal health education activities with individuals			11.2	Contributing to meetings at which broad professional issues are discussed
10.2	Undertaking informal health education activities with families/carers			12.7	Inputting data to computerised information management systems
10.8	Delivering formal health education activities to individuals			12.8	Managing a budget
10.9	Delivering formal health education activities to families			12.12	Writing discharge letters to GPs
10.11	Educating patients/carers in the use of equipment in community settings			12.13	Managing nurse-led clinics
11.2	Contributing to meetings at which broad professional issues are discussed			12.14	Initiating and maintaining the use of patient-held records
12.1	Reviewing workload priorities as a response to changing contexts			13.4	Dealing personally with patients/families/carers who make a complaint
12.7	Inputting data to computerised management information systems				

	COMMUNITY SETTINGS		HOSPITAL SETTINGS		COMBINED SETTINGS
1213	Managing nurse led clinics				
1214	Initiating and maintaining the use of client held records				
131	Using counselling skills in dealings with clients				

APPENDIX J

Appendix J: Mental Health Nursing - Current Cruciality (Cruciality C)

ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY C	RANK
Establishing an informal, relaxed working relationship with patients/clients	175	94	1
Recognising the effects of prescribed drugs and drug interactions	159	85	2
Actively participating in multi-disciplinary team meetings	152	81	3
Undertaking comprehensive health care needs assessment of individuals	151	81	4
Assessing social life skills	149	80	5
Actively working with consultants	141	75	6
Making a daily assessment of all clients for whom i am responsible	135	72	7
Establishing a trusting relationship with a client who finds trust difficult	130	70	8
Fostering autonomy of clients in relation to health care decisions	125	67	9
Interpreting and applying health and safety legislation	124	66	10
Working with a client who exhibits challenging behaviour	120	64	11
Actively working with occupational therapists	119	64	12
Collaborating with the multi-disciplinary team in delivery of the care programme approach	118	63	13
Drawing up contracts of care with individual clients	118	63	14
Negotiating a care package for individual clients	114	61	15
Managing care within the context of change	111	59	16
Undertaking informal health education activities with individuals	107	57	17
Maintaining and monitoring long term relationships with individuals, families or other social groups for health maintenance	107	57	18
Participating in meetings in which decisions are made regarding the selection of key workers	104	56	19
Operating as a mentor for students and staff	104	56	20
Monitoring the actions of others to whom responsibility for patient care has been delegated	103	55	21
Actively working with social workers	103	55	22
Contributing to shared multi-disciplinary team patient notes/records	101	54	23
Acting as patient/client advocate regarding quality of life issues	100	53.5	24
Interpreting and applying the mental health act	99	53	25

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ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY C	RANK
Assessing, anticipating and diffusing aggression	98	52	26
Interpreting and applying the community care act	97	52	27
Making and acting upon decisions which carry risks to clients	96	51	28
Participating in a process of clinical supervision	94	50	29
Carrying out physical assessment of clients	94	50	30
Reviewing workload priorities as a response to changing contexts	88	47	31
Actively working with pharmacists	87	46	32
Managing the allocation of patients/clients to a multi-skilled team	86	46	33
Assessing student nurses	83	44	34
Coordinating the multi-disciplinary team in discharge planning	82	44	35
Actively working with gps	76	41	36
Evaluating quality improvements to assure the on-going quality of nursing services	76	41	37
Working within a framework of an established model of counselling	76	41	38
Planning systems of nursing activity which satisfy agreed standards at local, unit or district level	76	41	39
Challenging institutional practices	75	40	40
Writing discharge letters to gps	67	36	41
Disseminating information about educational resources and opportunities	62	33	42
Undertaking informal health education activities with families and carers	59	32	43
Undertaking nursing practice in settings physically remote from colleagues	58	31	44
Working in conjunction with the voluntary and private sectors	58	31	45
Taking the final decision to discharge clients within defined protocols	57	31	46
Facilitating group therapy meetings	56	30	47
Negotiating and retaining access to patients homes	56	30	48
Having patient/client contact in both hospital and community settings	56	30	49
Participating in the writing of shared protocols for care	56	30	50
Collaborating with the multi-disciplinary team in reaching clinical decisions in ethically challenging situations	55	29	51
Actively working with psychologists	55	29	52

ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY C	RANK
Making and acting upon decisions which carry risks to the self	54	29	53
Participating in multi-disciplinary standard setting	53	28	54
Using a formal model of counselling	51	27	55
Handling catharsis	49	26	56
Establishing a therapeutic relationship with a client who presents with a history of sexual abuse	48	26	57
Participating in multi-disciplinary audit	48	26	58
Maintaining a personal and professional portfolio	47	25	59
Allocating patients to diagnostic groups on the basis of which treatment is initiated	46	25	60
Managing personnel issues and policies	43	23	61
Undertaking practice sensitive to the needs of patients/clients from multi-cultural backgrounds	43	23	62
Undertaking comprehensive health care needs assessment of families	38	20	63
Assessing neurological function	38	20	64
Transporting drugs outside hospital premises	38	20	65
Making and acting upon decisions which carry risks to families	37	20	66
Undertaking evaluation strategies with the use of audit tools	36	19	67
Contributing to the care of clients who are homeless	34	18	68
Contributing to meetings at which broad professional issues are discussed	34	18	69
Administering and disposing of medicines (including controlled drugs) outside the hospital situation	34	18	70
Dealing with formal requests for information from organisations outside the nhs	32	17	71
Giving formal counselling supervision	31	17	72
Making and acting upon decisions which carry risks to the organisation	31	17	73
Taking the final decision to admit clients to hospital within protocol criteria	31	17	74
Making appropriate referrals when clients seek legal advice	30	16	75
Chairing meetings	28	15	76
Completing reflective diaries	28	15	77
Managing nurse-led clinics	24	13	78
Dealing personally with patients, their families or carers who make a complaint	23	12	79

ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY C	RANK
Contributing to meetings regarding the business strategy of the trust	22	12	80
Communicating research findings to staff through formal and informal processes	20	11	81
Managing a budget	20	11	82
Inputting data to computerised information management systems	20	11	83
Contributing to the care of clients undertaking custodial sentences	18	10	84
Making and acting upon decisions which carry risks to communities	18	10	85
Formally presenting a case for change	17	9	86
Assessing national vocational qualifications (nvq) competencies	15	8	87
Effecting change based on research findings	15	8	88
Critically analysing the findings of research studies	14	7	89
Prescribing drugs within protocols	12	6	90
Identifying researchable problems	12	6	91
Accessing local data bases held on computer	12	6	92
Contributing to the care of clients who are subject to probation orders	11	6	93
Actively working with chiropodists/podiatrists	11	6	94
Interpreting and applying the children act	11	6	95
Actively working with dieticians	11	6	96
Attending meetings called for the purposes of child protection	10	5	97
Undertaking comprehensive health care needs assessment of communities	10	5	98
Using computer held data to inform the evaluation of client care outcomes	9	5	99
Writing or collaborating in writing a research proposal	8	4	100
Adjusting patient medication in response to laboratory findings	8	4	101
Confirming expected death	4	2	102
Actively working with probation officers	4	2	103
Attending court hearings/tribunals and engagement with the criminal justice system	4	2	104
Interpreting blood results and adjusting treatment accordingly	2	1	105
Being accountable for and personally administering electro-convulsive therapy	1	1	106
Accessing national data bases held on computer	1	1	107

APPENDIX K

Appendix K: Mental Health N. ng - Predicted cruciality (cruciality P)

	ELEMENT OF COMPETENCE	No OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
13.1	Establishing an informal, relaxed working relationship with patients/clients	167	89	1	83
3.8	Recognising the effects of prescribed drugs and drug interactions	159	85	2	85
3.1	Undertaking comprehensive health care needs assessment of individuals	150	80	3	84
7.1	Actively participating in multi-disciplinary team meetings	147	79	4	86
5.6	Assessing, anticipating and diffusing agression	147	79	5	80
13.7	Establishing a trusting relationship with a client who finds trust difficult	143	77	6	83
7.6	Actively working with consultants	134	72	7	76
12.10	Negotiating a care package for individual clients	134	72	8	57
3.4	Assessing social life skills	132	71	9	86
4.1	Interpreting and applying the Mental Health Act	133	71	10	77
3.7	Making a daily assessment of all clients for whom i am responsible	131	70	11	71
10.5	Assessing student nurses	130	70	12	21
7.17	Collaborating with the multi-disciplinary team in delivery of the care programme approach	129	69	13	73
12.2	Monitoring the actions of others to whom responsibility for patient care has been delegated	127	68	14	26
4.1	Making and acting upon decisions which carry risks to clients	127	68	15	51
10.6	Participating in a process of clinical supervision	126	67	16	29
1.10	Working with a client who exhibits challenging behaviour	123	66	17	80
2.5	Drawing up contracts of care with individual clients	122	65	18	80
10.3	Operating as a mentor for students and staff	121	65	19	26
2.1	Fostering autonomy of clients in relation to health care decisions	119	64	20	80
12.4	Managing care within the context of change	118	63	21	41
4.8	Interpreting and applying the Community Care Act	112	60	22	67
13.8	Dealing personally with patients, their families or carers who make a complaint	112	60	23	36
4.7	Interpreting and applying health and safety legislation	113	60	24	78
4.15	Making and acting upon decisions which carry risks to the self	113	60	25	56
2.4	Acting as patient/client advocate regarding quality of life issues	110	59	26	63

	ELEMENT OF COMPETENCE	No OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
2.2	Maintaining and monitoring long term relationships with individuals, families or other social groups for health maintenance	110	59	27	62
7.11	Coordinating the multi-disciplinary team in discharge planning	108	58	28	52
7.2	Actively working with social workers	107	57	29	78
7.8	Actively working with GPs	104	56	30	64
12.1	Reviewing workload priorities as a response to changing contexts	104	56	31	37
7.15	Contributing to shared multi-disciplinary team patient notes/records	105	56	32	66
1.6	Challenging institutional practices	105	56	33	72
13.2	Establishing a therapeutic relationship with a client who presents with a history of sexual abuse	105	56	34	58
10.1	Undertaking informal health education activities with individuals	102	55	35	75
7.10	Participating in meetings in which decisions are made regarding the selection of key workers	103	55	36	60
9.2	Maintaining a personal and professional portfolio	103	55	37	57
12.3	Mamanging the allocation of patients/clients to a multi-skilled team	102	55	38	28
7.17	Collaborating with the multi-disciplinary team in reaching clinical decisions in ethically challenging situations	100	54	39	73
7.3	Actively working with occupational therapists	101	54	40	81
3.9	Carrying out physical assessment of clients	97	52	41	77
13.3	Working within a framework of an established model of counselling	93	50	42	60
1.2	Undertaking practice sensitive to the needs pf patients/clients from multi-cultural backgrounds	90	48	43	86
12.11	Taking the final decision to discharge clients within defined protocols	90	48	44	24
7.7	Actively working with psychologists	88	47	45	76
12.12	Writing discharge letters to gps	86	46	46	35
10.2	Undertaking informal health education activities with families and carers	86	46	47	66
6.6	Evaluating quality improvements to assure the on-going quality of nursing services	84	45	48	44
7.12	Partipiating in multi-disciplinary standard setting	83	44	49	46
7.9	Actively working with pharmacists	83	44	50	69
10.7	Disseminating information about educational resources and opportunities	82	44	51	36
4.2	Making and acting upon decisions which carry risks to families	81	43	52	36
13.4	Using a formal model of counselling	78	42	53	49

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	ELEMENT OF COMPETENCE	No OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
13.6	Handling catharsis	77	41	54	44
7.13	Participating in the writing of shared protocols for care	77	41	55	44
4.14	Facilitating group therapy meetings	74	40	56	51
6.7	Participating in multi-disciplinary audit	74	40	57	33
1.1	Having patient/client contact in both hospital and community settings	75	40	58	82
4.4	Making and acting upon decisions which carry risks to the organisation	73	39	59	24
12.11	Taking the final decision to admit clients to hospital within protocol criteria	69	37	60	24
11.2	Contributing to meetings at which broad professional issues are discussed	70	37	61	24
6.5	Planning systems of nursing activity which satisfy agreed standards at local, unit or district level	70	37	62	37
13.5	Giving formal counselling supervision	68	36	63	23
8.4	Effecting change based on research findings	67	36	64	39
4.6	Administering and disposing of medicines (including controlled drugs) outside the hospital situation	67	36	65	32
1.3	Working in conjunction with the voluntary and private sectors	67	36	66	65
3.2	Undertaking comprehensive health care needs assessment of families	65	35	67	52
1.4	Negotiating and retaining access to patients homes	63	34	68	47
11.3	Formally presenting a case for change	64	34	69	20
4.5	Transporting drugs outside hospital premises	60	32	70	32
4.13	Allocating patients to diagnostic groups on the basis of which treatment is initiated	59	32	71	35
4.3	Making and acting upon decisions which carry risks to communities	60	32	72	23
8.5	Critically analysing the findings of research studies	57	31	73	48
12.13	Managing nurse-led clinics	57	31	74	16
3.5	Assessing neurological function	57	30	75	43
11.1	Contributing to meetings regarding the business strategy of the trust	56	30	76	11
12.9	Managing personel issues and policies	54	29	77	19
10.4	Assessing National Vocational Qualifications (NVQ) competencies	54	29	78	9
9.1	Completing reflective diaries	54	29	79	64
12.5	Dealing with formal requests for information from organisations outside the NHS	52	28	80	24
1.5	Undertaking nursing practice in settings physisally remote from colleagues	52	28	81	25

	ELEMENT OF COMPETENCE	No OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
8.3	Communicating research findings to staff through formal and informal processes	52	28	82	49
2.3	Making appropriate referalls when clients seek legal advice	50	27	83	35
6.2	Undertaking evaluation strategies with the use of audit tools	49	26	84	37
1.7	Contributing to the care of clients who are homeless	49	26	85	46
8.1	Identifying researchable problems	46	25	86	52
5.1	Adjusting patient medication in response to laboratory findings	47	25	87	16
5.2	Interpreting blood results and adjusting treatment accordingly	46	25	88	18
12.8	Managing a budget	40	21	89	12
4.12	Attending meetings called for the purposes of child protection	39	21	90	24
5.4	Prescribing drugs within protocols	37	20	91	10
7.5	Actively working with dieticians	37	20	922	63
4.9	Interpreting and applying the Children Act	37	20	93	41
8.2	Writing or collobarating in writing a research proposal	35	19	94	47
12.6	Chairing meetings	35	19	95	21
5.3	Confirming expected death	32	17	96	16
12.7	Inputting data to computerised information management systems	30	16	97	27
6.1	Using computer held data to inform the evaluation of client care outcomes	28	15	98	39
3.3	Undertaking comprehensive health care needs assessment of communities	28	15	99	28
6.3	Accessing local data bases held on computer	26	14	100	31
4.11	Attending court hearings/tribunals and engagement with the criminal justice system	26	14	101	18
7.4	Actively working with chiropodists/podiatrists	25	13	102	47
1.9	Contributing to the care of clients who are subject to probation orders	23	12	103	31
7.16	Actively working with probation officers	21	11	104	21
1.8	Contributing to the care of clients undertaking custodial sentences	21	11	105	30
6.4	Accessing national data bases held on computer	18	10	106	24
5.5	Being accountable for and personally admistering electro-convulsive therapy	13	7	107	2

APPENDIX L

Cruciality Index

Appendix L Adult Nursing - Current cruciality (cruciality C)

ELEMENT OF COMPETENCE	NO OF RESPONDENTS	RANK	CRUCIALITY C
Undertaking comprehensive health care needs assessment (individuals)	179	1	82
Carrying out physical assessment of patients/clients	153	2	67
Fostering autonomy of patients/clients in relation to health care decisions	154	3	67
Using counselling skills in dealing with clients	146	4	64
Recognising the effects of prescribed drugs and drug interactions	145	5	63
Undertaking informal health ed. activities with individuals	145	6	63
Maintaining and monitoring long term relationships with individuals and other social groups for health maintenance	139	7	61
Interpreting/applying health and safety legislation	133	8	58
Using counselling skills with patient's families	127	9	56
Initiating and maintaining patient/client held records	126	10	55
Making a daily assessment of clients for whom responsible	122	11	53
Assessing social/life skills	118	12	52
Actively working with GPs	113	13	49
Undertaking informal health ed. with families and carers	110	14	48
Reviewing workload priorities in response to changing contexts	108	15	47
Operating as a mentor for students/staff	106	16	46
Monitoring the actions of others to whom patient/client care responsibility has been delegated	101	17	44
Managing care within the context of change	98	18	43
Acting as patient client advocate regarding quality of life issues	95	19	42
Making and acting upon decisions which carry risks to patients	92	20	40
Negotiating and retaining access to patient's homes	91	21	40
Undertaking health screening programmes	92	22	40
Undertaking nursing practice in settings physically remote from colleagues	91	23	40
Actively participating in multi-disciplinary team meetings	89	24	39
Managing the allocation of patients to a multi-skilled team	90	25	39
Undertaking comprehensive health care needs assessment of families	89	26	39
Maintaining a personal and professional portfolio	87	27	38
Dealing with public health issues	86	28	38
Using counselling skills in dealings with colleagues	88	29	38
Actively working with consultants	86	30	38
Contributing to shared multidisciplinary team patient notes/records	87	31	38
Participating in clinical supervision	86	32	38

ELEMENT OF COMPETENCE	NO OF RESPONDENTS	RANK	CRUCIALITY C
Actively working with pharmacists	85	33	37
Negotiating a care package for individual patients/clients	81	34	35
Interpreting/applying the community care Act	78	35	34
Actively working with social workers	75	36	33
Carrying out venepuncture	72	37	31
Undertaking practice sensitive to the needs of patients from multi-cultural backgrounds	71	38	31
Evaluating quality improvements to assure the on-going quality of nursing services	71	39	31
Managing nurse-led clinics	69	40	30
Delivering formal health education programmes to individuals	68	41	30
Planning systems of nursing activity which satisfy agreed standards at local, unit or district levels	68	42	30
Inputting data to computerised information management systems	64	43	28
Taking the final decision to discharge patients/clients within defined protocols	65	44	28
Supporting junior medical colleagues	64	45	28
Working in conjunction with the voluntary and private sectors	65	46	28
Actively working with dieticians	62	47	27
Educating patients/clients/carers in the use of equipment in community settings	59	48	26
Assessing student nurses	60	49	26
Disseminating information about ed. resources and opportunities to staff	58	50	25
Interpreting/applying the Children Act	56	51	25
Undertaking evaluation strategies with the use of audit tools	55	52	24
Actively working with physiotherapists	54	53	24
Assessing neurological function	51	54	22
Coordinating the multidisciplinary team in discharge planning	49	55	21
Using computer held data to inform the evaluation of client care outcomes	48	56	21
Completing reflective diaries	49	57	21
Administration of IV drugs	47	58	21
Administration and disposal of medicines outside the hospital setting	48	59	21
Delivering formal health ed. to families	46	60	20
Actively working with OTs	44	61	19
Managing personnel issues and policies	41	62	18
Having patient contact in both hospital and community settings	39	63	17
Accessing local databases on computer	38	64	17
Participating in meetings in which decisions are made regarding selection of key workers	38	65	17

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ELEMENT OF COMPETENCE	NO OF RESPONDENTS	RANK	CRUCIALITY C
Participating in the writing of shared care protocols	37	66	16
Actively working with speech therapists	34	67	15
Carrying out male catheterisation	35	68	15
Undertaking comprehensive health care needs assessment of communities	32	69	14
Effecting change based on research findings	33	70	14
Making and acting upon decisions which carry risks to families	33	71	14
Participating in multi-disciplinary standard setting	33	72	14
Dealing with formal requests for information from organisations outside the NHS	29	73	13
Participating in multi-disciplinary clinical audit	30	74	13
Participating in decisions related to resuscitation based on quality of life indicators	27	75	12
Assessing NVQ competencies	28	76	12
Communicating research findings to staff through formal and informal processes	28	77	12
Contributing to meetings at which broad professional issues are discussed	25	78	11
Dealing personally with patients/carers who make a complaint	25	79	11
Identifying researchable problems	25	80	11
Critically analysing the findings of research studies	25	81	11
Adjusting patient medication in response to lab findings	22	82	10
Interpreting blood results and adjusting treatment accordingly	23	83	10
Allocating patients/clients to diagnostic groups on the basis of which treatment is initiated	23	84	10
Prescribing drugs within protocols	22	85	10
Actively working with ODAs	22	86	10
Initiating and IV regime within protocols	23	87	10
Writing discharge letters to GPs	23	88	10
Actively working with audiologists	20	89	9
Making appropriate referrals when patients/clients seek legal advice	21	90	9
Running cervical cytology clinics	21	91	9
Attending child protection meetings	20	92	9
Managing and monitoring CVP lines	21	93	9
Making and acting upon decisions which carry risks to the organisation	19	94	8
Actively working with chiropodists/podiatrists	18	95	8
Assisting the surgeon	18	96	8
Undertaking breast examination	15	97	7
Confirming expected death	16	98	7

ELEMENT OF COMPETENCE	NO OF RESPONDENTS	RANK	CRUCIALITY C
Inserting a peripheral IV cannula	15	99	7
Collaborating with multidisciplinary team in reaching clinical decisions in ethically challenging situations	15	100	7
Taking the final decision to admit patients to hospital within protocol criteria	13	101	6
Actively working with psychologists	11	102	5
Contributing to trust business strategy meetings	11	103	5
Formally presenting a case for change	11	104	5
Managing a budget	17	105	4
Chairing meetings	9	106	4
Taking blood from arterial lines	10	107	4
Assisting with the induction of anaesthesia	8	108	4
Removing foreign bodies from the eye	8	109	4
Writing or collaborating in writing a research proposal	7	110	3
Transporting drugs from outside hospital premises	7	111	3
Interpreting/applying the Mental Health Act	7	112	3
Facilitating group therapy meetings	6	113	3
Making and acting upon decisions which carry risks to communities	6	114	3
Carrying out defibrillation	4	115	2
Accessing national computer databases	4	116	2
Interpreting x-rays	4	117	2
Carrying out intubation/extubation	3	118	1
Attending court hearings/tribunals and engagement with the criminal justice system	2	119	1
Undertaking pelvic or prostrate exam	3	120	1
Assisting with tracheostomy formation	3	121	1

APPENDIX M

Appendix M Adult Nursing - Predicted cruciality (cruciality P)

	ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
3.1	Undertaking comprehensive health care needs assessment (individuals)	179	78	1	66
13.1	Using counselling skills in dealing with clients	175	76	2	49
13.2	Using counselling skills with patient's families	164	72	3	47
3.8	Recognising the effects of prescribed drugs and drug interactions	165	72	4	64
3.9	Carrying out physical assessment of patients/clients	161	70	5	64
10.1	Undertaking informal health education activities with individuals	155	68	6	62
10.3	Operating as a mentor for students/staff	153	67	7	14
2.1	Fostering autonomy of patients/clients in relation to health care decisions	150	66	8	53
13.3	Using counselling skills in dealings with colleagues	150	66	9	37
2.2	Maintaining and monitoring long term relationships with individuals and other social groups for health maintenance	144	63	10	41
10.2	Undertaking informal health education with families and carers	144	63	11	55
7.8	Actively working with GPs	144	63	12	41
4.7	Interpreting/applying health and safety legislation	141	62	13	66
7.1	Actively participating in multi-disciplinary team meetings	137	60	14	48
12.14	Initiating and maintaining patient/client held records	135	59	15	35
13.4	Dealing personally with patients/carers who make a complaint	135	59	16	24
12.4	Managing care within the context of change	130	57	17	28
3.7	Making a daily assessment of clients for whom responsible	131	57	18	48
2.4	Acting as patient client advocate regarding quality of life issues	127	56	19	38
12.2	Monitoring the actions of others to whom patient/client care responsibility has been delegated	125	55	20	15
12.1	Reviewing workload priorities in response to changing contexts	126	55	21	26
10.6	Participating in clinical supervision	123	54	22	14
12.10	Negotiating a care package for individual patients/clients	123	54	23	29
1.2	Undertaking practice sensitive to the needs of patients from multi-cultural backgrounds	119	52	24	76
4.1	Making and acting upon decisions which c to patients	119	52	25	31
8.4	Effecting change based on research findin	116	51	26	40
12.3	Managing the allocation of patients to a multi-skilled team	117	51	27	18
6.6	Evaluating quality improvements to assure the on-going quality of nursing services	116	51	28	34

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	ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
7.2	Actively working with social workers	116	51	29	46
1.7	Undertaking health screening programmes	115	50	30	45
7.15	Contributing to shared multidisciplinary team patient notes/records	114	50	31	40
10.5	Assessing student nurses	115	50	32	6
1.6	Dealing with public health issues	114	50	33	61
3.2	Undertaking comprehensive health care needs assessment of families	115	50	34	48
10.8	Delivering formal health ed/programmes to individuals	111	49	35	21
3.4	Assessing social/life skills	113	49	36	56
7.6	Actively working with consultants	110	48	37	47
12.13	Managing nurse-led clinics	110	48	38	11
5.8	Carrying out venepuncture	107	47	39	16
7.13	Participating in the writing of shared care protocols	102	45	40	27
6.5	Planning systems of nursing activity which satisfy agreed standards at local, unit or district levels	102	45	41	28
7.9	Actively working with pharmacists	104	45	42	39
4.9	Interpreting/applying the Children Act	101	44	43	42
9.1	Completing reflective diaries	101	44	44	60
5.4	Prescribing drugs within protocols	100	44	45	8
10.7	Disseminating information about educational resources and opportunities to staff	101	44	46	18
10.11	Educating patients/clients/carers in the use of equipment in community settings	99	43	47	30
4.8	Interpreting/applying the Community Care Act	99	43	48	48
7.5	Actively working with dieticians	98	43	49	51
10.9	Delivering formal health education to families	96	42	50	21
10.10	Supporting junior medical colleagues	97	42	51	11
12.11	Taking the final decision to discharge patients/clients within defined protocols	93	41	52	10
11.2	Contributing to meetings at which broad professional issues are discussed	94	41	53	17
7.12	Participating in multi-disciplinary standard setting	93	41	54	26
8.1	Identifying researchable problems	93	41	55	53
1.4	Negotiating and retaining access to patient's homes	94	41	56	36
8.5	Critically analysing the findings of research studies	93	41	57	42
7.14	Collaborating with multidisciplinary team in reaching clinical decisions in ethically challenging situations	92	40	58	19
8.3	Communicating research findings to staff through formal and informal processes	89	39	59	47

	ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
4.12	Attending child protection meetings	90	39	60	20
7.11	Coordinating the multidisciplinary team in discharge planning	90	39	61	30
6.2	Undertaking evaluation strategies with the use of audit tools	89	39	62	34
6.7	Participating in multi-disciplinary clinical audit	88	38	63	25
6.3	Accessing local databases on computer	84	37	64	31
1.5	Undertaking nursing practice in settings physically remote from colleagues	85	37	65	28
4.6	Administration and disposal of medicines outside the hospital setting	83	36	66	19
3.5	Assessing neuro function	82	36	67	51
7.16	Actively working with physiotherapists	83	36	68	50
5.12	Administration of IV drugs	82	36	69	7
6.1	Using computer held data to inform the evaluation of client care outcomes	79	35	70	38
7.3	Actively working with OTs	80	35	71	49
11.3	Formally presenting a case for change	79	35	72	14
7.10	Participating in meetings in which decisions are made regarding selection of key workers	77	34	73	23
12.9	Managing personnel issues and policies	76	33	74	13
2.5	Participating in decisions related to resuscitation based on quality of life indicators	74	32	75	19
12.7	Inputting data to computerised information management systems	70	31	76	33
4.2	Making and acting upon decisions which carry risks to families	71	31	77	21
5.2	Interpreting blood results and adjusting treatment accordingly	71	31	78	6
5.6	Managing and monitoring CVP lines	69	30	79	26
5.1	Adjusting patient medication in response to lab findings	68	30	80	8
5.14	Carrying out male catheterisation	69	30	81	24
10.4	Assessing NVQ competencies	66	29	82	6
8.2	Writing or collaborating in writing a research proposal	65	28	83	42
5.3	Confirming expected death	63	28	84	11
7.17	Actively working with speech therapists	65	28	85	47
12.8	Managing a budget	65	28	86	9
2.3	Making appropriate referrals when patients/clients seek legal advice	59	26	87	19
1.1	Having patient contact in both hospital and community settings	59	26	88	57
5.10	Inserting a peripheral IV cannula	59	26	89	7
1.3	Working in conjunction with the voluntary and private sectors	58	25	90	49
11.1	Contributing to trust business strategy meetings	57	25	91	10

	ELEMENT OF COMPETENCE	NO OF RESPONDENTS	CRUCIALITY P	RANK	PRE REG %
7.7	Actively working with psychologists	57	25	92	37
3.3	Undertaking comprehensive health care needs assessment of communities	58	25	93	28
5.11	Initiating an IV regime within protocols	55	24	94	7
5.2	Undertaking breast examination	55	24	95	24
12.5	Dealing with formal requests for information from organisations outside the NHS	54	24	96	11
12.12	Writing discharge letters to GPs	53	23	97	14
7.4	Actively working with chiropodists/podiatrists	52	23	98	44
5.7	Taking blood from arterial lines	51	22	99	8
5.9	Carrying out defibrillation	49	21	100	9
4.10	Interpreting/applying the Mental Health Act	48	21	101	32
9.2	Maintaining a personal and professional portfolio	49	21	102	64
7.18	Actively working with audioligists	49	21	103	41
4.13	Allocating patients/clients to diagnostic groups on the basis of which treatment is initiated	48	21	104	14
5.13	Running cervical cytology clinics	48	21	105	5
4.5	Transporting drugs from outside hospital premises	46	20	106	12
3.6	Taking the final decision to admit patients to hospital within protocol criteria	45	20	107	9
5.5	Carrying out intubation/extubation	45	20	108	7
6.4	Accessing national computer databases	43	19	109	26
4.4	Making and acting upon decisions which carry risks to the organisation	42	18	110	13
4.11	Attending court hearings/tribunals and engagement with the criminal justice system	39	17	111	9
4.3	Making and acting upon decisions which carry risks to communities	36	16	112	12
5.18	Removing foreign bodies from the eye	36	16	113	21
5.16	Assisting the surgeon	34	15	114	25
5.17	Assisting with tracheostomy formation	31	14	115	15
5.21	Undertaking pelvic or prostrate exam	32	14	116	11
12.6	Chairing meetings	31	14	117	11
7.19	Actively working with ODAs	30	13	118	41
5.19	Interpreting x-rays	28	12	119	11
5.15	Assisting with the induction of anaesthesia	27	12	120	19
4.14	Facilitating group therapy meetings	26	11	121	11

APPENDIX N

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